

**WISCONSIN MEDICAID PROGRAM 2017 NURSING HOME COST REPORT**

Completion of this form is required by Section 1.171 of the Methods of Implementation for Wisconsin Medicaid Nursing Home Payment Rates (Methods). Failure to complete and submit this form by the due date may result in a reduction or forfeiture of the payment rate, as provided in Section 49.45(13), Wis. Stats.

**SCHEDULE 1 - FACILITY AND PREPARER INFORMATION AND CERTIFICATION****SECTION A - FACILITY INFORMATION**

Facility Name ManorCare Health Services - Fond du Lac		Main Telephone Number 419-252-5796		Main E-Mail Address kcousino@hcr-manorcare.com	
Facility Street Address 265 South National Avenue		City Fond du Lac		State WI	Zip Code 54935
Contact Person Kim Cousino		Contact Telephone Number 419-252-5796		Contact E-Mail Address kcousino@hcr-manorcare.com	Corporate Facility Number 444
Cost Report Period Start Date 6/1/2016	Cost Report Period End Date 5/31/2017	Medicaid Provider Number 20199900	National Provider Identifier (NPI) 1730135179	POP ID Number 536	
Administrator Stacy Nies		Chief Financial Officer Matt Kang	Where are the financial records of the nursing home located? HCR ManorCare 333 N. Summit St. Toledo, OH 43604		

**SECTION B - PREPARER OF THE REPORT IF NOT AN EMPLOYEE OF THE PROVIDER**

Name and Title			Telephone Number		
Address		City	State	Zip Code	
SIGNATURE - Original Signature of Preparer			Date Signed		

**SECTION C - CERTIFICATION BY AN OFFICER OR ADMINISTRATOR OF THE NURSING HOME**

This certification must be signed and submitted before the information included in the cost report can be used to calculate Medicaid payment rates. Misrepresentation or falsification of any information contained in this report may be punishable by fine and/or imprisonment under state or federal law.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying report and any supporting schedules.

I HEREBY CERTIFY that to the best of my knowledge and belief, it is a true, correct, and complete report prepared from the books and records of the provider in accordance with applicable instructions, except as noted in the report.

SIGNATURE - Original Signature of Officer or Administrator of Nursing Home		Title	Date Signed
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**SCHEDULE 2 - PROVIDER'S NOTES, COMMENTS AND QUALIFICATIONS REGARDING THE MEDICAID  
NURSING HOME COST REPORT**

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**INSTRUCTIONS:** This schedule may be used by the nursing home administrator, owners, officers and cost report preparers to provide notes, comments or qualifications regarding the financial and statistical data reported in the accompanying cost report. Attach additional sheets if necessary.

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Commentator's Name	Title	Date
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### SCHEDULE 3 - GENERAL INFORMATION

1. Type of Medicaid certification (check all that apply)	<input checked="" type="checkbox"/> (01) Nursing Facility	<input type="checkbox"/> (10) ICF-IID	
2. Type of license (check all that apply)	<input checked="" type="checkbox"/> (01) Skilled Nursing	<input type="checkbox"/> (20) Developmentally Disabled	
	<input type="checkbox"/> (10) Intermediate Care	<input type="checkbox"/> (40) IMD	
3. Type of ownership (check one)	<input checked="" type="checkbox"/> (1) Proprietary	<input type="checkbox"/> (2) Voluntary Non-Profit	<input type="checkbox"/> (3) Governmental

4. County of facility <b>Fond du Lac</b>	County Code <b>20</b>
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5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed.	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No
6. Does the facility provide laundry services to residents for personal clothing?	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No
7. Are any employees of the facility covered by a union contract?	<input type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (2) No
8. Is the facility Medicare (Title XVIII) certified?	<input checked="" type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No

9. Fiscal Year Beginning Month <b>Jun</b>	Fiscal Year Ending Month <b>May</b>
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10. List the number of licensed beds at the beginning and end of your cost reporting period. Do not include restricted beds.

	DATE	BEDS
Beds at Beginning of Cost Reporting Period	6/1/2016	108
Beds at End of Cost Reporting Period	5/31/2017	108
_____	_____	_____
_____	_____	_____

If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.

11. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements.	<input type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (2) No
12. Check all related party transaction types for which expenses are reported.	<input type="checkbox"/> (1) Related party lease of building	<input type="checkbox"/> (2) Compensation to owners/family relation
	<input type="checkbox"/> (3) Interest expense on related party loans	<input checked="" type="checkbox"/> (4) Other related party transactions

13A. A final adjusted trial balance for the cost reporting period, including a reconciliation of the trial balance to the cost report must be submitted with this cost report. Have copies been made and included with this cost report?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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13B. Asset depreciation schedules detailing amounts reported on Schedule 34 - Depreciation expenses must be submitted. Have copies been made and included with this cost report?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No
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**14. Single occupancy rooms:** On the right side of the license effective on the last day of the cost report period, you will find the capacity of 1 BED, 2 BED, 3 BED, and 4 BED rooms. Add the number of beds labeled 1 BED and enter it in column C (Single-Bed Rooms). Add the number of beds on all other lines and enter it in column D (Beds in Multiple-Bed Rooms). Add the number of beds in single rooms (column C) to the number of beds in multiple-bed rooms (column D) and enter the total in Column E (Total Licensed Beds). This total must agree with the maximum capacity shown on your license. If your facility has more than one license, list each license on a separate line and total for each column.

A. NAME	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1. ManorCare of Fond du Lac WI, LLC	2743	1	107	108
2. _____	_____	_____	_____	-
3. _____	_____	_____	_____	-
4. TOTAL .....	_____	1	107	108

### SCHEDULE 4 - MAJOR REVENUE GENERATING ACTIVITIES

Identify all major revenue generating activities with which the Medicaid nursing home provider is associated.	Check services shared with the nursing home							
	Nursing	Sp. Care	Dietary	Maint.	Hskg.	Laundry	A & G	Util.
1. Another Medicaid NH provider, Name of provider:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Hospital, Name of hospital: Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Non-Medicaid NH unit or structure, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Non-Medicaid CBRF, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Room and board unit or structure, Beds at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Apartment units, Units at end of cost report period:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. School, Describe: Does school serve students under 21? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Outpatient mental health clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Contract with county mental health/disability board for special services to NH patients, Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Therapy services, Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Laboratory or radiology services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Rental of building space	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Elderly or other day care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Elderly home care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Fund raising activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Farm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Food catering services (meals on wheels, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Child care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Other, Describe:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Any items checked in Columns L - AG?      1 = Yes      0 = No	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>

**SCHEDULE 5 - BUILDING SQUARE FOOTAGE**

<b>SECTION A - GENERAL INFORMATION</b>	<b>WING A</b>	<b>WING B</b>	<b>WING C</b>	<b>WING D</b>
Name or description of building or wing .....	Original Bldg			
Year construction was functionally completed on building or wing .....	1965			
Total square footage of building or wing .....	29,114			
<b>SECTION B - NURSING HOME SERVICE AREAS</b>				
1. Nuns or other employees' housing .....				
2. Employees' unique fringe benefit areas .....	448			
3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup) . . .	3,267			
4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.) . . .	1,093			
5. Laundry (washing/drying room, sorting/folding rooms, central linen storage) . . .	812			
6. Administration (general/accounting offices, reception areas, meeting rooms) . .	1,362			
7. Laboratory & radiology .....				
8. Pharmacy .....				
9. Physical therapy .....	464			
10. Occupational therapy .....	315			
11. Other therapies .....	132			
12. Beauty and barber shops .....	132			
13. Gift shop, canteen, snack shop .....				
14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.) . . . .	20,730			
<b>SECTION C - RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY</b>				
15. Hospital direct patient service areas .....				
16. _____				
17. _____				
18. _____				
<b>SECTION D - OTHER AREAS</b>				
19. Major idle or closed areas .....				
20. Residual unidentified square footage (Total area less lines 1 through 19) .....	359			
Describe general purpose or use of Line 20 square footage: <u>common area</u>				

**SCHEDULE 6 - TOTAL PATIENT DAYS**

<b>SECTION A - INHOUSE PATIENT DAYS</b>	<b>LEVEL OF CARE (LOC)</b>		<b>TOTAL</b>
	<b>NON DD</b>	<b>DD</b>	
1a. Medicaid (T-19) .....	10,290		10,290
1b. ICF-IID Medicaid (T-19) .....			-
1c. Family Care (T-19) .....	6,376		6,376
1d. Other Medicaid Managed Care (T-19) .....			-
1e. Hospice (T-19) .....	1,110		1,110
1f. Ventilator (T-19) .....			-
2a. Medicare (T-18) .....	2,248		2,248
2b. Medicare Advantage, for days covered as a Part A stay			-
3a. Private pay & Insurance .....	5,541		5,541
3b. Medicare Advantage, for days not covered as a Part A stay			-
4. Other, Specify: _____			
5. TOTAL INHOUSE PATIENT DAYS .....	25,565	-	25,565

<b>SECTION B - BED HOLD DAYS</b>			<b>TOTAL</b>
	<b>NON DD</b>	<b>DD</b>	
<b>Charged Bed Hold Days Only</b>			
6a. Medicaid (T-19) .....			-
6b. ICF-IID Medicaid (T-19) .....			-
6c. Family Care & Partnership (T-19) .....			-
7. All Other .....	11		11
8. TOTAL CHARGED BED HOLD DAYS .....	11	-	11

<b>SECTION C - TOTAL PATIENT DAYS</b>	<b>NON DD</b>	<b>DD</b>	<b>TOTAL</b>
9. TOTAL DAYS (lines 5 + 8) .....	25,576	-	25,576

**SCHEDULE 7 - NO LONGER USED**

Information is now on Schedule 6

**SCHEDULE 8 - TOTAL PATIENT DAYS BY MONTH**

(Required)

1. MONTH . . . . .	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	TOTAL
2. Days in Month . . . . .	30	31	31	30	31	30	31	31	28	31	30	31	365
Licensed Beds for Bed Hold Testing . . . . .	108	108	108	108	108	108	108	108	108	108	108	108	1,296
4. Occupancy Test:													
Row 2 X (Row 3 X 94%)	3,046	3,147	3,147	3,046	3,147	3,046	3,147	3,147	2,843	3,147	3,046	3,147	37,056
5. Inhouse patient days	2,157	2,149	2,058	2,110	2,265	2,224	2,173	2,175	1,946	2,148	2,012	2,148	25,565
6. Bed Hold days . . . . .	-	4	-	-	2	1	2	2	-	-	-	-	11
7. <b>TOTAL DAYS . . . . .</b>	<b>2,157</b>	<b>2,153</b>	<b>2,058</b>	<b>2,110</b>	<b>2,267</b>	<b>2,225</b>	<b>2,175</b>	<b>2,177</b>	<b>1,946</b>	<b>2,148</b>	<b>2,012</b>	<b>2,148</b>	<b>25,576</b>

Explanation for why Licensed Beds for Bed Hold Testing are less than Licensed Beds: \_\_\_\_\_

NOTE: If "Occupancy Test" on line 4 is greater than the "Total Days" on Line 7, bed hold should not be billed in the following month.

**SCHEDULE 9A - HOSPICE PATIENT DAYS - NO LONGER USED**

Information is now on Schedule 6

**SCHEDULE 9B - VENTILATOR DEPENDENT PATIENT DAYS - NO LONGER USED**

Information is now on Schedule 6







## SCHEDULE 11 - SUMMARY OF REVENUES AND EXPENSES

All values are automatically posted from other schedules.

### SECTION A - SUMMARY OF REVENUE

1. Daily patient service revenue .....	schedule 14, lines 1-4	\$	6,254,856
2. Service fees .....	schedule 15, line 14A		2,490,453
3. Rent from outside medical providers .....	schedule 15, line 14B		-
4. Other .....	schedule 15, line 14C		-
5. Dietary revenues .....	schedule 16, line 5A		-
6. Miscellaneous services and materials revenue .....	schedule 16, line 16		4,479
7. Rental revenues .....	schedule 17, line 21A		-
8. Revenues from other major activities .....	schedule 17, line 37		-
9. Sales to related organizations .....	schedule 18, line 41		-
10. Investment revenue .....	schedule 18, line 45		93
11. Gains (Losses) on disposal of assets .....	schedule 18, line 47		-
12. Grants for government-subsidized employees .....	schedule 18, line 48		-
13. Grants, contributions, donations .....	schedule 18, line 49		-
14. Other revenue .....	schedule 18, line 54		567
15. Subtract: deductions from revenues .....	schedule 14, line 5	(	2,524,747 )
16. NET REVENUES .....		\$	6,225,701

### SECTION B - SUMMARY OF NET INCOME OR LOSS

17. Subtract: total expenses .....	schedule 12, line 38	\$ (	6,603,691 )
18. Add or subtract the amount to adjust related party transactions to cost .....	schedule 42, line 15		-
19. NET INCOME OR LOSS .....		\$	(377,990)

**SCHEDULE 12 - SUMMARY OF TOTAL EXPENSES**

All values are automatically posted from other schedules.

Cost Center	Reference	Expense	Cost Center	Reference	Expense
1. Daily patient service expense . . . . .	S20, L10	\$ 2,292,927	20. Transportation . . . . .	S25, L19f	\$ 8,166
2. Laboratory & Radiology . . . . .	S21, L15a	24,124	21. Administrative service expense . . . . .	S26, L12	1,085,490
3. Respiratory . . . . .	S21, L15b	36,916	Other cost centers, Specify:		
4. Pharmacy . . . . .	S21, L15c	160,226	22. Nurse Aide Training	S27, L15a	
5. PT, OT and Speech . . . . .	S22, L15a	596,781	23. Beauty/Barber Shop	S27, L15b	4,775
6. Dental . . . . .	S22, L15b	-	24. 0	S27, L15c	
7. Physician . . . . .	S22, L15c	10,200	25. 0	S27, L15d	
8. Social Services . . . . .	S23, L15a	106,693	26. 0	S27, L15e	
9. Recreational Activities . . . . .	S23, L15b	102,988	UNASSIGNED EXPENSES		
10. Religious Services . . . . .	S23, L15c	-	27. Employee fringe benefit expense . . . . .	S28, L17	1,064,850
11. Volunteer Coordinator . . . . .	S24, L15a	-	28. Heating fuel and utility expense . . . . .	S29, L10	113,553
12. Ward Clerks . . . . .	S24, L15b	-	29. Interest on operating working capital loans	S30, L6	-
13. Psychotherapy . . . . .	S24, L15c	-	30. Insurance expense . . . . .	S31, L9	18,119
14. Other . . . . .	S24, L15d	-	31. Amortization expense . . . . .	S32, L5	-
15. Dietary . . . . .	S25, L19a	362,049	32. Interest on plant asset loans . . . . .	S33, L15h	-
16. Plant Operations and Maintenance . . . . .	S25, L19b	141,809	33. Depreciation expense . . . . .	S34, L20c	149,553
17. Housekeeping . . . . .	S25, L19c	148,630	34. Expense on operating and non-cap.leases	S35, L14	45,878
18. Laundry and Linen . . . . .	S25, L19d	45,941	35. Expense on capitalized leases . . . . .	S36A, L5	-
19. Security . . . . .	S25, L19e	7,827	36. Property tax expense . . . . .	S37, L9	76,196
			37. Other non-salary expense . . . . .	S39, L4	-
			<b>38. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38) . .</b>		<b>\$ 6,603,691</b>

(To schedule 11, line 17)

**SCHEDULE 13 - SUMMARY OF SALARY AND WAGE EXPENSES**

All values are automatically posted from other schedules.

Cost Center and Schedule		Total Salary and Wage Expense (Line 1 or 5)	Cost Center and Schedule		Total Salary and Wage Expense (Line 1 or 5)
Daily patient service . . . . .	S20, L1e	\$ 2,119,446	Dietary . . . . .	S25, L1a	192,002
Laboratory & Radiology . . . . .	S21, L1a	-	Plant operation / maintenance . . . . .	S25, L1b	42,989
Respiratory . . . . .	S21, L1b & 3b	-	Housekeeping . . . . .	S25, L1c	129,032
Pharmacy . . . . .	S21, L1c & 3c	631	Laundry and Linen . . . . .	S25, L1d	26,871
PT, OT and Speech . . . . .	S22, L1a & 3a	584,328	Security . . . . .	S25, L1e	-
Dental . . . . .	S22, L1b & 3b	-	Transportation . . . . .	S25, L1f	-
Physician . . . . .	S22, L1c & 3c	-	Administrative service . . . . .	S26, L1e	397,157
Social Services . . . . .	S23, L3a	106,650	Nurse aide training . . . . .	S27, L1a	-
Recreational Activities . . . . .	S23, L3b	100,754	Beauty and barber . . . . .	S27, L1b	-
Religious Services . . . . .	S23, L3c	-	Other, Specify: 0	S27, L1c	-
Volunteer Coordinator . . . . .	S24, L1a & 3a	-	0		-
Ward Clerks . . . . .	S24, L1b & 3b	-	0		-
Psychotherapy . . . . .	S24, L1c & 3c	-			
Other . . . . .	S24, L1d & 3d	-	<b>TOTAL SALARY AND WAGE EXPENSE . . . . .</b>		<b>\$ 3,699,860</b>

### SCHEDULE 14 - DAILY PATIENT SERVICE REVENUES

**INSTRUCTIONS:** If a facility has received its retroactive Medicaid rate adjustment, the adjusted revenues should be included in line 2 for the months of service in the cost reporting period. Some facilities may have not received the retroactive Medicaid rate adjustments due to them for services provided during the months of the cost reporting period.

**SECTION A - DAILY RATE CHARGES**

	<b>Revenue</b>
1. Medicare Daily Rate	\$2,102,142
2. Medicaid Daily Rate (including bed hold)	<u>2,945,758</u>
3. Private Pay	<u>558,812</u>
4. Medical Supplies, Other	<u>648,144</u>

**SECTION B - Deductions From Revenue**

5. TOTAL DEDUCTIONS FROM REVENUE ( 2,524,747 )

**SECTION C - TOTAL**

6. TOTAL DAILY PATIENT SERVICE REVENUE \$ 3,730,109

Do Medicaid revenues on Line 2 include retroactive Medicaid rate adjustments? (check one)

- Yes, all significant retroactive Medicaid rate adjustments are included.
- No, substantial retroactive Medicaid rate adjustments are NOT included.
- Estimate, an estimate of retroactive Medicaid rate adjustments IS included
- Other, Specify \_\_\_\_\_

**Average Daily Private Pay Rate**

5. Average Daily \$242.32

6. Facility Comment (Optional) \_\_\_\_\_

### SCHEDULE 15 - SPECIAL SERVICE REVENUES

**INSTRUCTIONS:** Refer to schedules 25A, 25B, 26B, 29, and 40 and their instructions regarding the allocation of general services and property expenses to those building areas which are used for providing the revenue generating services or which are rented out for those services. If applicable, administrative service expenses must be allocated to the revenue generating service.

For Column B (Rent Revenue), describe the rental fee basis (example: rent per month, percent of charges) and the services, equipment, and square feet of space furnished to the outside provider. Add additional sheets if necessary.

SECTION A - SERVICE REVENUES	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory . . . . .	\$ 26,863			
2. Radiology . . . . .	5,103			
3. Pharmacy . . . . .	255,020			
4. Physical therapy . . . . .	613,179			
5. Speech/hearing therapy . . . . .	285,890			
6. Occupational therapy . . . . .	720,737			
7. Physician care . . . . .				
8. Psychotherapy . . . . .				
9. Respiratory therapy	88,302			
10. Social services . . . . .				
11. Recreational activities . . . . .				
12. Special duty nursing . . . . .				
13. Other, Specify: <u>eq rental, iv therapy</u>	495,359			
14. TOTAL SPECIAL SERVICE REVENUE . .	\$ 2,490,453	\$ -	\$ -	

If totals exceed \$4,000, see instructions above.

#### SECTION B - THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?  Yes  No
16. Total gross revenues for physical, occupational, and speech therapy services provided at your facility during the cost report period \$ 1,619,806  
Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).
17. From section A, total the amounts in columns A, B and C on lines 4, 5 and 6 (sum 4A, 4B, 4C, 5A, 5B, 5C, 6A, 6B, 6C) \$ 1,619,806
18. If there is any variance between the totals reported on lines 16 and 17, explain. \_\_\_\_\_
- 
19. Are therapy services provided to individuals in addition to your nursing home residents?  Yes  No If yes, amount of revenue \$ 30,600
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?  Yes  No If yes, amount of revenue \$ 337,261
21. Did you charge rent to a rehabilitation agency or independent contractor?  Yes  No If yes, amount of revenue \_\_\_\_\_

**SCHEDULE 16 - OTHER REVENUES**

**SECTION A - CAFETERIA AND DIETARY REVENUE**

1. Donated and surplus food commodities . . . . .	_____	Included in food supply expense for donated/surpl	_____
2. Dietary supplies sold . . . . .	_____	Cost of dietary supplies sold (if known) . . . . .	_____
3. Meals sold to employees (transfer to sched. 25A, line 10) . . . . .	_____		
4. Meals On Wheels . . . . .	_____		
5. Other Meals Sold . . . . .	_____		
<b>5a. TOTAL DIETARY REVENUE . . . . .</b>	<b>\$ _____ -</b>		

**SECTION B - MISCELLANEOUS SERVICES AND MATERIALS**

	Revenue	Expenses Directly Ascribable To Or Identifiable With Revenue			
		A. Related Direct Expense (if known)	B. Cost Center where expense included	C. Schedule Number	D. Line Number
6. Laundry . . . . .	_____	_____	_____	_____	_____
7. Sale of personal hygiene items . . . . .	_____	_____	_____	_____	_____
8. Transportation . . . . .	_____	_____	_____	_____	_____
9. Beauty and barber shops . . . . .	4,479	4,775	B & B	27	15
10. Gift Shop . . . . .	_____	_____	_____	_____	_____
11. Canteen and snack counter . . . . .	_____	_____	_____	_____	_____
12. Vending machines . . . . .	_____	_____	_____	_____	_____
13. Sale of clothing . . . . .	_____	_____	_____	_____	_____
14. Television and cable service . . . . .	_____	_____	_____	_____	_____
15. Telephone and Internet . . . . .	_____	_____	_____	_____	_____
<b>16. TOTAL MISCELLANEOUS SERVICES AND MATERIALS</b>	<b>\$ 4,479</b>				

### SCHEDULE 17 - OTHER REVENUES

**INSTRUCTIONS:** For Section C, refer to schedules 25A, 25B, 29 and 40 and their instructions regarding the allocation of expenses to rented equipment or building space. For section D, only report revenues if the direct expenses and the shared and indirect expenses associated with the revenue activity are reported in this cost report. See schedule 4 or Section 700 of the instructions for more details on the reporting of expenses.

<b>SECTION C - RENTAL REVENUE</b>	<b>Revenue</b>	<b>Property Rented</b>	<b>Square Feet Rented</b>	<b>Services Provided</b>
18. Equipment rental . . . . .	_____	_____	_____	_____
19. Rental of nursing home space . . . . .	_____	_____	_____	_____
20. Rental of non-nursing home space . . . . .	_____	_____	_____	_____
21. Parking . . . . .	_____	_____	_____	_____
<b>21a. TOTAL RENTAL REVENUES . . . . .</b>	<b>\$ -</b>			

<b>SECTION D - REVENUE FROM MAJOR ACTIVITIES</b>	<b>Revenue</b>	<b>Total Billable Patient Days if revenue generated from activities 24,25,26</b>
22. Another Medicaid nursing home provider . . . . .	_____	_____
23. Hospital . . . . .	_____	_____
24. A non-Medicaid nursing home unit . . . . .	_____	_____
25. A non-Medicaid residential facility (CBRF) . . . . .	_____	_____
26. Room and board unit or structure . . . . .	_____	_____
27. Apartment Units . . . . .	_____	_____
28. Child Care Institution . . . . .	_____	_____
29. School . . . . .	_____	_____
30. Outpatient mental health clinic . . . . .	_____	_____
31. Elderly or other day care . . . . .	_____	_____
32. Elderly home care . . . . .	_____	_____
33. Farm . . . . .	_____	_____
34. _____	_____	_____
35. _____	_____	_____
36. _____	_____	_____
<b>37. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES . . . . .</b>	<b>\$ -</b>	



**SCHEDULE 18 - OTHER REVENUES**

<b>SECTION E - SALES TO RELATED ORGANIZATIONS</b>		<b>Revenue</b>	<b>SECTION H - GRANTS FOR GOVT. SUBSIDIZED EMP.</b>		<b>Revenue</b>
38.			48.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES . . . . .	
39.					
40.					
41.	TOTAL SALES TO RELATED ORGANIZATIONS	<b>\$ -</b>			

<b>SECTION F - INTEREST AND INVESTMENT REVENUE</b>		<b>Revenue</b>
42.	Revenues from invested gift/grant funds not commingled with other funds . . . . .	
43.	Revenue from invested funds used for current cash needs . . . .	93
44.	Other revenue from invested funds . . . . .	
45.	TOTAL INVESTMENT REVENUE . . . . .	<b>\$ 93</b>
46.	If total investment revenue exceeds \$6,000, describe major investments (type, invested amount, purpose if any)	
	<hr/>	
	<hr/>	
	<hr/>	

<b>SECTION I - GRANTS, CONTRIBUTIONS, DONATIONS</b>		<b>Revenue</b>
49.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS . . . . .	

<b>SECTION G - GAINS (LOSSES) DISPOSAL OF ASSETS</b>		<b>Gain (Loss)</b>
47.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS . . . . .	

<b>SECTION J - OTHER REVENUES</b>		<b>Revenue</b>
50.	Purchase discounts	\$ 567
51.		
52.		
53.		
54.	TOTAL OTHER REVENUES . . . . .	<b>\$ 567</b>

**SCHEDULE 20 - DAILY PATIENT SERVICE EXPENSE**

	A. Registered Nurses	B. Licensed Practical Nurses	C. Nurse Aides and Assistants	D. Resident Living Staff	E. Total Expense/Hrs. (sum A-D)
<b>SALARIES, WAGES PURCHASED SERV.</b>					
1. TOTAL SALARY AND WAGE EXPENSE	\$ 1,055,500	\$ 232,408	\$ 831,538		\$ 2,119,446
2. TOTAL SALARY AND WAGE HOURS	33,422 hrs.	10,155 hrs.	60,747 hrs.		\$ 104,324
3. EXPENSE FOR PURCHASED SERVICES					\$ -
<b>NURSING AND INCONTINENCY SUPPLIES</b>					
4. Catheters, Incontinency Supplies (including purchased laundry service)					\$ 45,537
<b>OXYGEN</b>					
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental					
<b>OTHER</b>					
6. Other medical supplies, personal comfort supplies and minor medical equipment					99,517
7. Nonbillable over the counter (OTC) drugs for all residents (include other OTC drugs billable on drug claim forms schedule 21, line 11)					18,687
8. <u>Adm Alloc Nursing</u>					88
9. <u>Purch Svc Medical Svc</u>					9,652
<b>10. TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 1, 3, 4-9)</b>					<b>\$ 2,292,927</b>

**SCHEDULE 21 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Laboratory & Radiology	B. Respiratory	C. Pharmacy
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable			\$ 631
2. Number of hours worked - Billable			11 hrs.
3. Expense for hours worked - Non-billable	\$ -		
4. Number of hours worked - Non-billable	hrs.		
5. TOTAL SALARY AND WAGE EXPENSE	\$ -	\$ -	\$ 631
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	\$ 24,124		
7. Number of hours of purchased service - Billable (optional)			
8. Expense for purchased service - Non billable	\$ -		
9. Number of hours of purchased service - Non billable (optional)	hrs.		
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Pharmacy - legend drugs Billable	\$ -	\$ -	159,425
11. Pharmacy - over the counter drugs Billable	\$ -	\$ -	
12. Supply and Other		36,188	
13. Adm Alloc Pharmacy			170
14. Repairs		728	
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	\$ 24,124	\$ 36,916	\$ 160,226
16. TOTAL HOURS (Sum 2, 4, 7, 9)	hrs.	hrs.	11 hrs.

**SCHEDULE 22 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Physical, Occupational And Speech Therapy	B. Dental	C. Physician
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable. . . . .	\$ 584,328		
2. Number of hours worked - Billable. . . . .	16,395 hrs.		
3. Expense for hours worked - Non-billable. . . . .			
4. Number of hours worked - Non-billable. . . . .			
5. TOTAL SALARY AND WAGE EXPENSE	\$ 584,328	\$ -	\$ -
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable . . . . .			
7. Number of hours of purchased service - Billable (optional) . . . .			
8. Expense for purchased service - Non billable . . . . .			\$ 10,200
9. Number of hours of purchased service - Non billable (optional). . .			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Supplies	12,352		
11. Adm Alloc Therapy Mgmt	101		
12. _____			
13. _____			
14. _____			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$ 596,781	\$ -	\$ 10,200
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	16,395 hrs.	hrs.	hrs.

**SCHEDULE 23 - SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Social Services	B. Recreational Activities	C. Religious Services
<b>SECTION A - SALARY AND WAGES</b>			
1. Expense for hours worked - Billable	\$ -	\$ -	\$ -
2. Number of hours worked - Billable	hrs.	hrs.	hrs.
3. Expense for hours worked - Non-billable	\$ 106,650	\$ 100,754	
4. Number of hours worked - Non-billable	4,168 hrs.	7,197 hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	\$ 106,650	\$ 100,754	\$ -
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable . . . . .	\$ -	\$ -	\$ -
7. Number of hours of purchased service - Billable (optional) . . . . .	hrs.	hrs.	hrs.
8. Expense for purchased service - Non billable . . . . .		\$ 265	
9. Number of hours of purchased service - Non billable (optional) . . . . .			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
10. Supplies	\$ 17	\$ 1,969	
11. Minor equipment	26		
12.			
13.			
14.			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$ 106,693	\$ 102,988	\$ -
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	4,168 hrs.	7,197 hrs.	hrs.

**SCHEDULE 24 - OTHER TYPES OF SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE			
	A. Volunteer Coord.	B. Ward Clerks	C. Psychotherapy	
<b>SECTION A - SALARY AND WAGES</b>				
1. Expense for hours worked - Billable	\$ -	\$ -		
2. Number of hours worked - Billable	hrs.	hrs.		
3. Expense for hours worked - Non-billable				
4. Number of hours worked - Non-billable				
5. TOTAL SALARY AND WAGE EXPENSE	\$ -	\$ -	\$ -	\$ -
<b>SECTION B - PURCHASED SERVICES</b>				
6. Expense for purchased service - Billable . . . . .				
7. Number of hours of purchased service - Billable (optional) . . . .				
8. Expense for purchased service - Non billable . . . . .				
9. Number of hours of purchased service - Non billable (optional) . .				
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>				
10. _____				
11. _____				
12. _____				
13. _____				
14. _____				
<b>SECTION D - TOTAL</b>				
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$ -	\$ -	\$ -	
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	hrs.	hrs.	hrs.	hrs.

### SCHEDULE 25 - GENERAL SERVICE EXPENSES

SECTION A - SALARIES AND WAGES	A. Dietary	B. Plant Op./Maint.	C. Housekeeping	D. Laundry / Linen	E. Security	F. Transportation
1. TOTAL SALARY AND WAGE EXPENSE	\$ 192,002	\$ 42,989	\$ 129,032	\$ 26,871		
2. NUMBER OF HOURS WORKED	14,006 hrs.	2,096 hrs.	9,863 hrs.	2,396 hrs.		
Lines 3-5 are no longer used						
<b>SECTION B - DIETICIAN CONSULTANT</b>						
6. Dietician consultant expense		\$ -	\$ -	\$ -	\$ -	\$ -
Line 7 is no longer used						
<b>SECTION C - OUTSIDE SERVICE</b>						
8. Purchased service		\$ 310	\$ 6,904			
9.						
10. Purchased service		53,561				
11.						
12. TOTAL OUTSIDE SERVICE EXPENSES	\$ -	\$ 53,871	\$ 6,904	\$ -	\$ -	\$ -
<b>SECTION D - No longer used</b>						
<b>SECTION E - SUPPLY AND OTHER EXPENSE</b>						
13. Supplies	\$ 3,552	\$ 39,296	\$ 11,219	\$ 13,554		
14. Repairs, minor equipment	3,460	5,653	1,475	5,516		
15. Transportation						8,166
16. Food, suppl feeding	163,035					
17. Repairs					7,827	
<b>SECTION F - No longer used</b>						
<b>SECTION G - TOTAL</b>						
18. TOTAL EXPENSES .....	\$ 362,049	\$ 141,809	\$ 148,630	\$ 45,941	\$ 7,827	\$ 8,166
(Sum 1, 6, 8-11, 13-17)						

**SCHEDULE 25A - ALLOCATION OF DIETARY AND PLANT OPERATION AND MAINTENANCE EXPENSES**

**SECTION A - ALLOCATION OF DIETARY EXPENSES**

1. Total dietary expenses (from schedule 25, line 18)		\$ 362,049
2. Deduct expense for food products provided to employees without charge (to line 9 below)		
3. Deduct amount for donated and surplus food commodities included in dietary expense (from schedule 16, line 1) . . . . .		\$ -
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2)		\$ -
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below)		\$ 362,049

	A. Total	B. Residents'	C. Employees'	D. Meals on	E. Other	F. Other
		Meals	Meals	Wheels		
6. Meals served	76,695	76,695				
7. Ratio to total meals served to 4 decimals	1.0000	1.0000				
8. DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	\$ 362,049	\$ 362,049	\$ -	\$ -	\$ -	\$ -
	From line 5	8A X 7B	8A X 7C	8A X 7D	8A X 7E	8A X 7F
9. Food products provided to employes without charge (from line 2)			\$ -			
10. Deduct revenue from meals sold to employees (from schedule 16, line 3)			-			
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C)			\$ -			

**SECTION B - ALLOCATION OF PLANT OPERATION AND MAINTENANCE EXPENSES**

	A. Total	B. Nursing Home	C. Emp. Unique	Non-Nursing Home Areas w/ Plant Operation and Maint.		
	Area	Area	Fringe Benefit Area	D.	E.	F.
12. Total square feet for areas	29,114	28,666	448			
13. Ratio to total square feet to 4 decimals . .	1.0000	0.9846	0.0154			
14. TOTAL PATIENT OP/MAINT EXP. ALLOC.	\$ 141,809	\$ 139,625	\$ 2,184	\$ -	\$ -	\$ -
	From S25, L18	14A X 13B	14A X 13C	14A X 13D	14A X 13E	14A X 13F



**SCHEDULE 25B - ALLOCATION OF HOUSEKEEPING, LAUNDRY, SECURITY AND TRANSPORTATION**

**SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Non-Nursing Home Areas Receiving Housekeeping Services</u>		
15. Square feet or hours of service provided	29,114	29,114			
16. Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17. TOTAL HOUSEKEEPING EXP. ALLOC.	\$ 148,630	\$ 148,630	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>17A X 16B</small>	<small>17A X 16C</small>	<small>17A X 16D</small>	<small>17A X 16E</small>

**SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Non-Nursing Home Areas Receiving Laundry/Linen Services</u>		
18. Pounds of laundry processed	29,114	29,114			
19. Ratio to total pounds to 4 decimals . . . . .	1.0000	1.0000			
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	\$ 45,941	\$ 45,941	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>20A X 19B</small>	<small>20A X 19C</small>	<small>20A X 19D</small>	<small>20A X 19E</small>

**SECTION C - ALLOCATION OF SECURITY EXPENSES**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Non-Nursing Home Areas Receiving Security Services</u>		
21. Total square feet of area	29,114	29,114			
22. Ratio to total square feet to 4 decimals . .	1.0000	1.0000			
23. TOTAL SECURITY EXPENSE ALLOC.	\$ 7,827	\$ 7,827	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>23A X 22B</small>	<small>23A X 22C</small>	<small>23A X 22D</small>	<small>23A X 22E</small>

**SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>Non-Nursing Home Areas Receiving Transportation Services</u>		
24. Alloc. Basis, Specify: <u>square footage</u>	29,114	29,114			
25. Ratio to total alloc. basis to 4 decimals	1.0000	1.0000			
26. TOTAL TRANS. EXPENSE ALLOC.	\$ 8,166	\$ 8,166	\$ -	\$ -	\$ -
	<small>From S25, L18</small>	<small>26A X 25B</small>	<small>26A X 25C</small>	<small>26A X 25D</small>	<small>26A X 25E</small>

**SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES**

**INSTRUCTIONS:** For facilities managed by an outside, contracted management firm, the amount of management fee expense for the cost reporting period must be separately identified and reported on line 10 of this schedule. Enclose a copy of the management contract that was in effect during the cost reporting period.

<b>SECTION A - SALARY AND WAGES</b>	<b>A. General Admin. Serv.</b>	<b>B. Medical Records</b>	<b>C. Central Supply</b>	<b>D. Accounting/Other Serv.</b>	<b>E. TOTAL (sum A-D)</b>
1. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$ 361,926	\$ 21,291	\$ 13,940		\$ 397,157

**SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS**

6. Home office costs allocated to facility					\$ 200,463
7. County costs allocated to facility					

**SECTION C - NON-SALARY EXPENSES**

8. Purchased services - legal					\$ 49,562
9. Licensed bed assessment					220,320
10. Contractual management fees					
11. Total other non-salary (from schedule 26 attachment)					217,988

**SECTION D - TOTAL**

12. TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11)					\$ 1,085,490
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**SECTION E - HOME OFFICE COST ALLOCATION REPORT**

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office. A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office HCR ManorCare From (date) 1/1/2016 through (date) 12/31/2016

**SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES - RELATED PARTY**

**INSTRUCTIONS:** For facilities managed by an outside, contracted management firm, the amount of management fee expense for the cost reporting period must be separately identified and reported on line 10 of this schedule. Enclose a copy of the management contract that was in effect during the cost reporting period.

<b>SECTION A - SALARY AND WAGES</b>	<b>A. General Admin. Serv.</b>	<b>B. Medical Records</b>	<b>C. Central Supply</b>	<b>D. Accounting/Other Serv.</b>	<b>E. TOTAL (sum A-D)</b>
1. TOTAL SALARY AND WAGE EXPENSE . . . .	_____	_____	_____	_____	\$ _____ -

**SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS**

6. Home office costs allocated to facility	_____
7. County costs allocated to facility	_____

**SECTION C - NON-SALARY EXPENSES**

8. Purchased services - legal	_____
9. Licensed bed assessment	_____
10. Contractual management fees	_____
11. Total other non-salary (from schedule 26 attachment)	_____ -

**SECTION D - TOTAL**

12. TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11)	\$ _____ -
---	------------

**SECTION E - HOME OFFICE COST ALLOCATION REPORT**

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office. A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office \_\_\_\_\_ From (date) \_\_\_\_\_ through (date) \_\_\_\_\_

## SCHEDULE 26 ATTACHMENT - OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES

**INSTRUCTIONS:** Itemize the expenses for other non-salary administrative service expenses which are reported on schedule 26, line 11. Use account descriptions from the facility general ledger with as much detail as possible.

Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1. Association dues	\$ 6,080
2. Help wanted	11,737
3. Advertising - allowable	18,955
4. Advertising - nonallowable	-
5. Dues, subscriptions, licenses	32,846
6. Staff development	17,639
7.	
8. Supplies	14,578
9. Telecommunications	37,626
10. Minor equipment	11,891
11. Travel & entertainment	7,056
12. Background checks, AR sub fee	23,935
13. Purchased service, record retention	24,930
14. Customer reimbursement	5,215
15. Donations	5,500
<b>16. TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . .</b>	<b>\$ 217,988</b>

## SCHEDULE 26 ATTACHMENT - OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES - RELATED PARTY

**INSTRUCTIONS:** Itemize the expenses for other non-salary administrative service expenses which are reported on schedule 26, line 11. Use account descriptions from the facility general ledger with as much detail as possible.

Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____
11. _____	_____
12. _____	_____
13. _____	_____
14. _____	_____
15. _____	_____
<b>16. TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . .</b>	<b>\$ -</b>

**SCHEDULE 26B - ALLOCATION OF ADMINISTRATIVE EXPENSES**

**INSTRUCTIONS:** On line 17, enter the quantitative amounts for the allocation basis used by the facility. Describe the type of basis used and how it was determined.

1. Total Admin. Service Expense (S26, 12) \$ 1,085,490

**SECTION A - DIRECT EXPENSES**

**Non-Nursing Home Areas Receiving Administrative Services**

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider			
2. see trial balance for detail	\$ -	\$ -			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXP. (sum 2-14)	\$ -	\$ -			
16. NET UNASSIGNED EXP. (line 1-line 15)	<u>\$ 1,085,490</u>				

**SECTION B - ALLOC. OF INDIRECT EXP.**

	A. Total	B. NH Provider			
17. Allocation basis amounts	29,114	29,114			
18. Ratio to total basis to 4 decimals	1.0000	1.0000			
19. UNASSIGNED ADMIN. EXP. ALLOC	\$ 1,085,490	1,085,490	-	-	-
	net from line 16	19A X 18B	19A X 18C	19A X 18D	19A X 18E
20. TOTAL ADMINISTRATIVE EXPENSE	\$ 1,085,490	\$ 1,085,490	\$ -	\$ -	\$ -
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

**SCHEDULE 27 - OTHER COST CENTERS**

<b>SECTION A - SALARY AND WAGES</b>		<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>			
1.	TOTAL SALARY AND WAGE EXPENSE					
2.	NUMBER OF HOURS WORKED					
<b>SECTION B - NON-SALARY EXPENSES</b>		<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>	<b>-</b>	<b>-</b>	<b>-</b>
3.						
4.						
5.						
6.	Supplies		15			
7.						
8.						
9.	Purchased service		4,760			
10.						
11.						
12.						
13.						
14.						
15.	<b>TOTAL NON-SALARY EXPENSES</b>	<b>\$ -</b>	<b>\$ 4,775</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
<b>SECTION C - TOTAL</b>		<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>	<b>-</b>	<b>-</b>	<b>-</b>
16.	<b>TOTAL EXPENSES (Sum 1, 3-14) . . . . .</b>		<b>\$ 4,775</b>			

**SCHEDULE 28 - EMPLOYEE FRINGE BENEFIT EXPENSES**

**INSTRUCTIONS:** Under the column labeled "Self-Funded", indicate yes or no. If yes, attach documentation to support the amount claimed for each self-funded benefit.

**SECTION A - FRINGE BENEFITS PAID ON BEHALF OF EMPLOYEES**

Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1. Employer's share of F.I.C.A.		\$ 260,209
2. State unemployment compensation		26,302
3. Federal unemployemnt compensation		5,439
4. Worker's compensation insurance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	61,966
5. Health, Dental & Vision Insurance	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	681,960
6. Life and disability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	4,918
7. Wage continuation insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	
8. Pension and deferred comp. plans (section C)	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	18
9. Employee physicals and vaccines (if pre-employment, report costs on Sch 26-Attachment)		
10. Uniforms		6,277
11. <u>401K</u>		11,423
12. _____		
13. <u>Other employee benefits</u>		6,338
14. _____		
15. TOTAL PAID ON BEHALF OF EMPLOYEES (sum 1-14)		<b>\$ 1,064,850</b>
16. Expense for special salary or wage payments to employees not included elsewhere (section D)		
17. <b>TOTAL FRINGE BENEFIT EXPENSE(sum 15+16)</b>		<b>\$ 1,064,850</b>

**SECTION D - SPECIAL SALARY AND WAGE PAYMENTS TO EMPLOYEES**

**INSTRUCTIONS:** Check the types of special salary and wage payments to employees which are included in section A, line 16.

Christmas bonus     
  Longevity bonus     
  Productivity bonus     
  Other, Specify: \_\_\_\_\_

Bonuses to owners and immediate family relations, Specify: \_\_\_\_\_



### SCHEDULE 29 - HEATING FUEL AND UTILITY EXPENSES

**INSTRUCTIONS:** Report the accrued expense incurred during the cost reporting period for each type of heating fuel and utility service.

Accounts payable: The expense should be adjusted to excluded beginning accounts payable and to include ending accounts payable for the reporting period. Make sure to include exactly 12 months of expense for a full-year cost report and exactly six months of expense for a six-month cost report.

Inventories: The expense for heating and fuels such as heating oil, L.P. gas and coal should be adjusted for changes in inventories between the beginning and ending dates of the cost reporting period.

Cost allocation: In section B, allocate the fuel and utility expense between the Medicaid nursing home area and other major revenue-generating areas or non-nursing home areas.

Describe the allocation technique if an allocation basis other than square footage is used. The allocation basis used is similar to the maintenance allocation on schedule 25A.

**SECTION A - ACCRUED EXPENSE BY TYPE**

	Accrued Expense	Expense by Type		Accrued Expense
1. Fuel oil		6. Water and sewer utility charges		24,486
2. Natural gas	57,060	7. Purchased steam		
3. L.P. gas		8. _____		
4. Coal		9. _____		
5. Electricity	32,007	<b>10. TOTAL FUEL AND UTILITY EXPENSE . . .</b>	<b>\$</b>	<b>113,553</b>

**SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE**

	A. Total	B. NH Area	C. Emp. Unique Fringe Ben. Area	Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.		
11. Total square feet for areas	29,114	28,666	448			
12. Ratio to total square feet to 4 decimals	1.0000	0.9846	0.0154			
<b>13. TOTAL ALLOC. FUEL/UTIL. EXPENSE</b>	<b>113,553</b>	<b>\$ 111,804</b>	<b>\$ 1,749</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>
	From line 10	13A X 12B	13A X 12C	13A X 12D	13A X 12E	13A X 12F

### SCHEDULE 30 - INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS

	Name of Lender	Is Lender a Related Party?	Interest Expense
1a.	_____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2a.	_____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3a.	_____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4a.	_____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5a.	_____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6.	<b>TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5) .....</b>		<b>\$ _____ -</b>

### SCHEDULE 31 - INSURANCE EXPENSES

Type of Insurance Coverage	Self-Funded?	Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$ 3,879
2. Automobile insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	407
3. Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	13,729
4. Business interruption insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	104
5. Life insurance on owners and employes with facility as the beneficiary .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Mortgage insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. Other Property _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Other General _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. <b>TOTAL INSURANCE EXPENSE .....</b>		<b>\$ 18,119</b>

### SCHEDULE 32 - AMORTIZATION OF DEFERRED EXPENSES

A. Deferred Exp. Or Asset Being Amortized (give detailed description)	B. Original Cost	C. Year Cost Incurred	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1. _____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. <b>TOTAL AMORTIZATION EXPENSE .....</b>						<b>\$ _____ -</b>

### SCHEDULE 30 - INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS - RELATED PARTY

	Name of Lender	Is Lender a Related Party?	Interest Expense
1a.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2a.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3a.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4a.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5a.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6.	<b>TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5) .....</b>		<b>\$ -</b>

### SCHEDULE 31 - INSURANCE EXPENSES - RELATED PARTY

	Type of Insurance Coverage	Self-Funded?	Insurance Expense
1.	Property insurance on building and contents	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2.	Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3.	Liability insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4.	Business interruption insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5.	Life insurance on owners and employes with facility as the beneficiary .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6.	Mortgage insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8.	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9.	<b>TOTAL INSURANCE EXPENSE .....</b>		<b>\$ -</b>

### SCHEDULE 32 - AMORTIZATION OF DEFERRED EXPENSES - RELATED PARTY

	A. Deferred Exp. Or Asset Being Amortized (give detailed description)	B. Original Cost	C. Year Cost Incurred	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1.	_____	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____	_____
5.	<b>TOTAL AMORTIZATION EXPENSE .....</b>						<b>\$ -</b>

**SCHEDULE 33 - INTEREST EXPENSES ON PLANT ASSET LOANS**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date 6/1/2016 Begin Bal.	E. 6Mo.date 11/30/2016 6 Mo. Bal.	F. End date 5/31/2017 End Bal.		
1a. Name _____								
1b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
1c. Purpose _____								
2a. Name _____								
2b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
2c. Purpose _____								
3a. Name _____								
3b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
3c. Purpose _____								
4a. Name _____								
4b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
4c. Purpose _____								
5a. Name _____								
5b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
5c. Purpose _____								
6a. Name _____								
6b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
6c. Purpose _____								
7a. Name _____								
7b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
7c. Purpose _____								
<b>15 TOTAL LOAN PRINCIPAL .....</b>				<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>TOTAL EXP.....</b>	<b>\$ -</b>

**SCHEDULE 33, PAGE 2 - INTEREST EXPENSES ON PLANT ASSET LOANS**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date 6/1/2016 Begin Bal.	E. 6Mo.date 11/30/2016 6 Mo. Bal.	F. End date 5/31/2017 End Bal.		
8a. Name _____								
8b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
8c. Purpose _____								
9a. Name _____								
9b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
9c. Purpose _____								
10a. Name _____								
10b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
10c. Purpose _____								
11a. Name _____								
11b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
11c. Purpose _____								
12a. Name _____								
12b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
12c. Purpose _____								
13a. Name _____								
13b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
13c. Purpose _____								
14a. Name _____								
14b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____
14c. Purpose _____								
16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY				\$ -	\$ -	\$ -		\$ -
<b>SEE SCHEDULE 33 FOR TOTAL LOAN PRINCIPAL OF SCHEDULE 33 AND SCHEDULE 33, PAGE 2</b>								

**SCHEDULE 33 - INTEREST EXPENSES ON PLANT ASSET LOANS - RELATED PARTY**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date 6/1/2016 Begin Bal.	E. 6Mo.date 11/30/2016 6 Mo. Bal.	F. End date 5/31/2017 End Bal.		
1a. Name _____								
1b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
1c. Purpose _____								
2a. Name _____								
2b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
2c. Purpose _____								
3a. Name _____								
3b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
3c. Purpose _____								
4a. Name _____								
4b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
4c. Purpose _____								
5a. Name _____								
5b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
5c. Purpose _____								
6a. Name _____								
6b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
6c. Purpose _____								
7a. Name _____								
7b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No								
7c. Purpose _____								
<b>15 TOTAL RELATED PARTY LOAN PRINCIPAL .....</b>				<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>TOTAL EXP.....</b>	<b>\$ -</b>

**SCHEDULE 33, PAGE 2 - INTEREST EXPENSES ON PLANT ASSET LOANS - RELATED PARTY**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense	
				D. Begin date	E. 6Mo.date	F. End date			
				6/1/2016	11/30/2016	5/31/2017			
				Begin Bal.	6 Mo. Bal.	End Bal.			
8a. Name _____									
8b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
8c. Purpose _____									
9a. Name _____									
9b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
9c. Purpose _____									
10a. Name _____									
10b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
10c. Purpose _____									
11a. Name _____									
11b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
11c. Purpose _____									
12a. Name _____									
12b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
12c. Purpose _____									
13a. Name _____									
13b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
13c. Purpose _____									
14a. Name _____									
14b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____	_____	_____	_____	_____	
14c. Purpose _____									
16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY				\$	-	\$	-	\$	-
<b>SEE SCHEDULE 33- RELATED PARTY FOR TOTAL LOAN PRINCIPAL OF SCHEDULE 33 - RELATED PARTY AND SCHEDULE 33 - RELATED PARTY, PAGE 2</b>									

**SCHEDULE 34 - DEPRECIATION EXPENSES**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>6/1/2016</u>	C. Additions During Report	D. Disposals During Report	End Date <u>5/31/2017</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	97,293		( )	\$ 97,293
2. Land Improvements	215,436	5,395	( )	220,831
3. Buildings	1,664,220		( )	1,664,220
4. Leasehold Improvements	2,452,239	76,573	( )	2,528,812
5. Fixed equipment	-		( )	-
6. Moveable equipment	1,740,633	95,860	( 1,332 )	1,835,161
7. Transportation vehicles	-		( )	-
8. _____			( )	-
9. _____			( )	-
10. TOTAL CAPITALIZED COST . .	<b>\$ 6,169,821</b>	<b>\$ 177,828</b>	<b>( \$ 1,332 )</b>	<b>\$ 6,346,317</b>

**SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION**

	A. Depreciation	Begin Date <u>6/1/2016</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>5/31/2017</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements	straight line	\$ 118,562	\$ 17,095	( )	\$ 135,657
12. Buildings	straight line	1,609,524	3,395	( )	1,612,919
13. Leasehold Improvements	straight line	2,138,006	69,638	( )	2,207,644
14. Fixed equipment		-		( )	-
15. Moveable equipment	straight line	1,590,762	59,425	( 567 )	1,649,620
16. Transportation vehicles		-		( )	-
17. _____				( )	-
18. _____				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<b>\$ 5,456,854</b>		<b>( \$ 567 )</b>	<b>\$ 5,605,840</b>
<b>20. TOTAL DEPRECIATION EXPENSE</b>			<b>\$ 149,553</b>		

21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period \$ 11,586

Include copies of invoices to support the cost of any Bariatric Equipment (see sec. 2.750 of Methods of Implementation for definition) purchases reported on Line 21.

Include a copy of your plant ledger that supports the amounts reported on this Schedule 34 - See Schedule 3 Line 13 B



**SCHEDULE 34 - DEPRECIATION EXPENSES - RELATED PARTY**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date B. Beginning Balance	6/1/2016	C. Additions During Report Period	D. Disposals During Report Period (as negative value)	End Date E. Ending Balance	5/31/2017
1. Land	\$	-		( )	\$	-
2. Land Improvements		-		( )		-
3. Buildings		-		( )		-
4. Leasehold Improvements		-		( )		-
5. Fixed equipment		-		( )		-
6. Moveable equipment		-		( )		-
7. Transportation vehicles		-		( )		-
8. _____				( )		-
9. _____				( )		-
10. TOTAL CAPITALIZED COST . .	\$	-	\$ -	( \$ - )	\$	-

**SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION**

	A. Depreciation Method, Lives Used	Begin Date B. Beginning Balance	6/1/2016	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date E. Ending Balance	5/31/2017
11. Land Improvements		\$	-		( )	\$	-
12. Buildings			-		( )		-
13. Leasehold Improvements			-		( )		-
14. Fixed equipment			-		( )		-
15. Moveable equipment			-		( )		-
16. Transportation vehicles			-		( )		-
17. _____					( )		-
18. _____					( )		-
19. TOTAL ACCUMULATED DEPRECIATION		\$	-		( \$ - )	\$	-
20. TOTAL DEPRECIATION EXPENSE				\$ -			

21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period

Include copies of invoices to support the cost of any Bariatric Equipment (see sec. 2.750 of Methods of Implementation for definition) purchases reported on Line 21.

Include a copy of your plant ledger that supports the amounts reported on this Schedule 34 - See Schedule 3 Line 13 B

### SCHEDULE 35 - LEASE EXPENSES ON OPERATING LEASES AND NON-CAPITALIZED LEASES

**INSTRUCTIONS:** For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 34, 37 and 39. Label the schedule copies, "Related Party Leased Property".

For any lease contract expense which totals above \$5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider.

**SECTION A - LEASE EXPENSE FOR LAND, BUILDING AND FIXED EQUIPMENT**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

**SECTION B - LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
4. Joerns #625005-600	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	mattresses	\$ 19,767
5. UHS #625005-600	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	mattresses	3,968
6. Unlimited Advacare	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	broda chairs	16,590
7. Joerns #625010-653	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	mattresses	1,193
8. UHS #625010-653	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	mattresses	3,845
9. Eden Meat, Fond du Lac Equip	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	floor scrubber, trailer rental	158
10. Pitney Bowes	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	_____	Jun-16	postage meter	357
11. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
12. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____
13. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	_____	_____

**SECTION C - TOTAL**

14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES (sum 1-13) \$ 45,878

### SCHEDULE 36A - LEASE EXPENSES ON CAPITALIZED LEASES

**INSTRUCTIONS:** For any lessor that is a related party to the provider, report the lessor's ownership cost of the property and complete and attach copies of schedules 31, 32, 33, 33 page 2 (if applicable), 34, 37 and 39. Label the schedule copies, "Related Party Leased Property".

For any lease contract expense which totals above \$5,000, submit a copy of the lease.

Identify any of the leased property listed below which was formerly owned by the leasing provider on Schedule 36B.

**SECTION A - CAPITALIZED LEASE INFORMATION**

**Lease Expense**

<p>1. Name of lessor _____</p> <p>Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Beginning Lease Date _____</p> <p>Ending Lease Date _____</p> <p>Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Description of leased property _____</p>	<p>1a. Amortization of capitalized lease value _____</p> <p>1b. Interest expense on capital lease obligation _____</p> <p>1c. Accrued contingent lease payments for period . . . _____</p> <p>1d. SUBTOTAL LEASE EXPENSE (sum 1a-1c) _____</p>
<p>2. Name of lessor _____</p> <p>Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Beginning Lease Date _____</p> <p>Ending Lease Date _____</p> <p>Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Description of leased property _____</p>	<p>2a. Amortization of capitalized lease value _____</p> <p>2b. Interest expense on capital lease obligation _____</p> <p>2c. Accrued contingent lease payments for period . . . _____</p> <p>2d. SUBTOTAL LEASE EXPENSE (sum 2a-2c) _____</p>
<p>3. Name of lessor _____</p> <p>Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Beginning Lease Date _____</p> <p>Ending Lease Date _____</p> <p>Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Description of leased property _____</p>	<p>3a. Amortization of capitalized lease value _____</p> <p>3b. Interest expense on capital lease obligation _____</p> <p>3c. Accrued contingent lease payments for period . . . _____</p> <p>3d. SUBTOTAL LEASE EXPENSE (sum 1a-1c) _____</p>
<p>4. Name of lessor _____</p> <p>Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Beginning Lease Date _____</p> <p>Ending Lease Date _____</p> <p>Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Description of leased property _____</p>	<p>4a. Amortization of capitalized lease value _____</p> <p>4b. Interest expense on capital lease obligation _____</p> <p>4c. Accrued contingent lease payments for period . . . _____</p> <p>4d. SUBTOTAL LEASE EXPENSE (sum 1a-1c) _____</p>
<p>5. <b>TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD - Transfer to Schedule 12 (sum 1d+2d+3d+4d) . . . . .</b></p>	<p style="text-align: right;"><b>\$ _____ -</b></p>

### SCHEDULE 36B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

**INSTRUCTIONS:**

Identify any of the leased property listed below which was formerly owned by the leasing provider.

**SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES**

A1. Name of lessor \_\_\_\_\_

A3. Are any capitalized costs reported on other schedules? .....  Yes  No

B1. Name of lessor \_\_\_\_\_

B3. Are any capitalized costs reported on other schedules? .....  Yes  No

C1. Name of lessor \_\_\_\_\_

C3. Are any capitalized costs reported on other schedules? .....  Yes  No

D1. Name of lessor \_\_\_\_\_

D3. Are any capitalized costs reported on other schedules? .....  Yes  No

A2. Actual payments required by lease in report period . . . . \_\_\_\_\_

A4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

B2. Actual payments required by lease in report period . . . . \_\_\_\_\_

B4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

C2. Actual payments required by lease in report period . . . . \_\_\_\_\_

C4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

D2. Actual payments required by lease in report period . . . . \_\_\_\_\_

D4. If yes, (schedule) \_\_\_\_\_ (line) \_\_\_\_\_ (amount) \_\_\_\_\_

**E. TOTAL CAPITALIZED LEASE PAYMENTS RELATED TO CAPITALIZED LEASES (sum A2+B2+C2+D2) ..... \$ \_\_\_\_\_ -**

SCHEDULE 37 - PROPERTY TAX EXPENSES

INSTRUCTIONS: Only tax exempt facilities should report the expense for municipal services which are financed through municipality property taxes. Describe the services.

SECTION A - FOR ALL PROVIDERS

Table with 2 columns: Description and Expense. Row 1: 2017 real estate tax... \$ 69,090. Row 2: 2017 personal property tax... 7,106. Row 3: 3a. Have the amounts reported on lines 1 and 2 been paid in full? [x] Yes, go to question 3b [ ] No, explain below. Row 4: 3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2015 or 2016? [ ] Yes, explain below [x] No.

SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY

Table with 2 columns: Description and Expense. Row 4: Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2017. Row 5: Identify where municipal service fee expenses are reported in the cost report if not above on this schedule. Attach a copy of the bill. Row 6: The facility began to pay municipal service fees (check one) [ ] Prior to January 2017 [ ] On or after January 2017 Date began paying fees. Row 7: Describe the services provided by the municipality for the above fees. Row 8: Payment of the above fees was (check one) [ ] Voluntary [ ] Required by the tax authority. Row 9: TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE ..... \$ 76,196

SCHEDULE 37 - PROPERTY TAX EXPENSES - RELATED PARTY

INSTRUCTIONS: Only tax exempt facilities should report the expense for municipal services which are financed through municipality property taxes. Describe the services.

SECTION A - FOR ALL PROVIDERS

Expense

- 1. 2017 real estate tax (due in 2018) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)
2. 2017 personal property tax (due in 2018) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.)

3a. Have the amounts reported on lines 1 and 2 been paid in full? [ ] Yes, go to question 3b [ ] No, explain below

Date(s) paid \_\_\_\_\_ Amount(s) paid \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2015 or 2016? [ ] Yes, explain below [ ] No

Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_ Tax year \_\_\_\_\_ Amount still outstanding \_\_\_\_\_

SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY

Expense

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2017.

5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule, section A, line 7.

Cost center name \_\_\_\_\_ Schedule number \_\_\_\_\_ Line number \_\_\_\_\_ Amount reported \_\_\_\_\_

6. The facility began to pay municipal service fees (check one) [ ] Prior to January 2017 [ ] On or after January 2017 Date began paying fees \_\_\_\_\_

7. Describe the services provided by the municipality for the above fees.

8. Payment of the above fees was (check one) [ ] Voluntary [ ] Required by the tax authority

TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE ..... \$ -

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**SCHEDULE 38 - NO LONGER USED**

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**SCHEDULE 39 - OTHER NON-SALARY EXPENSES**

**INSTRUCTIONS:** Report and describe the nature and source of any non-salary expenses not included elsewhere in this cost report. Other salary expenses should be reported on schedule 27.

---

	Nature and Source of Expense	Expense
1.	<hr/>	<hr/>
2.	<hr/>	<hr/>
3.	<hr/>	<hr/>
4.	<b>TOTAL OTHER NON-SALARY EXPENSES (sum 1 - 3).....</b>	<b>\$ <u>-</u></b>

**SCHEDULE 40 - ALLOCATION OF PROPERTY EXPENSES**

**INSTRUCTIONS:** Assign expenses directly ascribable to or identifiable with each service's building area. Use column C for unique fringe benefit building areas.

	A. Total From Sched.	B. NH Service Area	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities		
			C.	D.	E.
<b>SECTION A - DIRECT PROPERTY EXP.</b>					
1. Property insurance (s31)	\$ 3,879				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	-				
4. Plant asset interest expense (s33)	-				
5. Depreciation land improvements (s34)	17,095				
6. Depreciation buildings (s34)	3,395				
7. Depreciation leasehold improve. (s34)	69,638				
8. Depreciation fixed equipment (s34)	-				
9. Depreciation moveable equip. (s34)	59,425				
10. Depreciation transportation veh. (s34)	-				
11. Depreciation other (s34)	-				
12. Expense on operating leases (s35)	45,878				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	76,196				
15. TOTAL EXPENSE (sum 1-14)	\$ 275,506	\$ -			
16. Less total directly assigned property exp.	\$ -	(sum 15B, 15C 15D, 15E)			
17. <b>NET UNASSIGNED/INDIRECT PROP. . . . .</b>	<b>\$ 275,506</b>	(15A less 16A)			
<b>SECTION B - NON-SALARY EXPENSES</b>					
18. Square feet of service's building area	29,114	29,114			
19. Ratio to total square feet to 4 decimals	1.0000	1.0000			
20. Indirect property expense allocation	\$ 275,506 (from 17A)	275,506 20A X 19B	- 20A X 19C	- 20A X 19D	- 20A X 19E
<b>SECTION C - TOTAL</b>					
21. <b>TOTAL PROP. EXP. FOR EACH AREA</b>	<b>\$ 275,506</b> 17A + 20 A	<b>\$ 275,506</b> 15B + 20B	<b>\$ -</b> 15C + 20C	<b>\$ -</b> 15D + 20D	<b>\$ -</b> 15E + 20E



### SCHEDULE 41 - ACCOUNTING AND REPORTING POLICIES

**SECTION A - POLICIES AND PRACTICES**

1. Accounting method - expenses are to be reported on the accrual method of accounting except for governmental facilities, which may use the cash method. Check the accounting method used in this cost report.  Accrual  Cash
2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.

3. Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report  
not applicable

4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.  
All conform to GAAP.

**SECTION B - NON-PRODUCTIVE SALARY EXPENSE AND HOURS**

**INSTRUCTIONS:** Reporting on the basis of earned time-off is not permitted. Vacation, Holiday and Sick Time (VS) salaries and hours must be reported on the basis of the time-off actually taken by employees during the cost reporting period. For column B, describe the estimation techniques used and add sheets if needed.

Type of Paid Time-Off	A. Based on Actual or Earned Time-Off?		B. Are Reported Amounts an Estimate?	
1. Vacation	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
2. Holidays	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
3. Sick time	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
4. Break, meal time	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
5. Holiday premium	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
6. In-service training	<input checked="" type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
7. _____	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**SCHEDULE 42 - IDENTIFICATION OF EXPENSES FROM TRANSACTIONS WITH RELATED PARTIES AND ORGANIZATIONS**

**SECTION A - RELATED PARTY LEASES**

A. Description of Expense Item	Location and Amount of Expense Included in This Cost Report					G. Expense Incurred by Related Party	H. Difference (G - F)
	B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Expense		
1. Total related party lease expense					( )	XXXXXXXXXX	XXXXXXXXXX
2. Insurance expense					XXXXXXXXXX		XXXXXXXXXX
3. Amortization deferred expense					XXXXXXXXXX		XXXXXXXXXX
4. Interest expense					XXXXXXXXXX		XXXXXXXXXX
5. Depreciation expense					XXXXXXXXXX		XXXXXXXXXX
6. Property tax expense					XXXXXXXXXX		XXXXXXXXXX
7. _____					XXXXXXXXXX		XXXXXXXXXX
8. _____					XXXXXXXXXX		XXXXXXXXXX
9. SUBTOTAL FOR RELATED PARTY LEASES					( \$ - )	\$ -	\$ -

**SECTION B - OTHER RELATED PARTY TRANSACTIONS**

10. Home Office	Adm & Gen	26	1	6	( \$ 200,463 )	\$ 200,463	\$ -
11. _____					( )		-
12. _____					( )		-
13. _____					( )		-
14. _____					( )		-
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18) .....							<u>-</u>

**SECTION C - IDENTIFICATION OF RELATED PARTIES**

16. List the names and cities of location of the related parties and organizations with whom the nursing home provider has transacted business during the cost report period.

HCR ManorCare Toledo, OH 43604

### SCHEDULE 43 - IDENTIFICATION OF EXPENSES NOT RELATED TO PATIENT CARE

**INSTRUCTIONS:** To the extent possible, identify significant expenses included in this cost report which were not related to patient care. See Section 600 of the Cost Report

Instructions for more details on such expenses. Attach additional sheets if necessary.

A. Description of Expense Item	Amount	Location of Expense in Cost Report			
		Cost Ctr.	Schedule	Column	Line
1. Promotional expenses					
2. Gifts and flowers					
3. Personal expenses of owners					
4. Entertainment for non-residents					
5. Telephone, television, internet and cable service in resident rooms					
6. Contributions and donations					
7. Fines and penalties					
8. Interest expense on non-care working capital loans					
9. Interest expense on non-care plant asset loans					
10. Non-care related membership fees					
11. Training programs for non-employees					
12. Special legal and professional fees (complete schedule 43A)					
13. Owner or key person life insurance					
14. Taxes					
15. Fund raising expenses					
16. Excess property					
17. Out of State Travel (Destination)					
18. Gift, flower, or coffee shops and snack counters					
19. Reorganization, stockholder, or stock purchase expenses					
20. Goodwill and Abandoned Planning Expenses					
21 Other - describe: <u>Provider Assessment</u>	220,320	Adm & Gen	26	1	9
22 Other - describe: <u>Barber &amp; Beauty</u>	4,775	B & B	27	2	15

### SCHEDULE 43A - LEGAL FEES

**INSTRUCTIONS:** Identify the expenses for all legal fees included in this cost report. These expenses should have been reported on schedule 26, line 8. For the fees reported on line 2, identify any allowable amount that was specifically awarded by the administrative or judicial courts as a result of a successful appeal or prosecution.

Description	Legal fees
1. Prosecution or defense related to Medicare or Medicaid reimbursement.....	
2. Prosecution or defense pertaining to compliance with licensure or certification requirements (see instructions above).....	
3. Defense of an owner or employee in a personal or criminal legal matter.....	
4. Legal preparation resulting in the filing of an appeal under Chapters 50 or 227, Wisconsin Statutes, or a judicial suit.....	
5. Collection of delinquent accounts.....	49,562
6. Corporate restructuring or reorganization.....	
7. Potential purchase or sale of nursing home(s).....	
8. Purchase or sale of nursing home(s).....	
9. Negotiations with suppliers.....	
10. Income taxes, payroll taxes, benefit plans.....	
11. Union related activities.....	
12. Guardianship for Medicaid residents.....	
13. Other not related to patient care.....	
14. _____	
15. _____	
<b>16. TOTAL LEGAL FEES (should equal schedule 26, line 8).</b> .....	<b>\$ 49,562</b>

### SCHEDULE 45 - DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL

**INSTRUCTIONS:** Separately itemize and identify the amount of compensation expense and hours reported in each cost center of this cost report. Report the compensation paid to all owners and other related parties and immediate family relationships, all workers who are members of a religious order or society that owns the nursing home, and arm's length employees who are supervisors or managers with decision making authority.

A. Name, Position	Location of Expense in Cost Report			Compensation & Hours		Purchased Serv.	
	B. Cost Ctr.	C. Schedule	D. Column	E. Expense	F. Hours	G. Expense	H. Hours
1. <u>Kristina Hittman</u>	<u>Soc Svc</u>	<u>23</u>	<u>1</u>	<u>\$ 50,202</u>	<u>2,080 hrs.</u>	<u>\$ -</u>	<u>hrs.</u>
2. <u>Stacy Nies</u>	<u>Adm &amp; Gen</u>	<u>26</u>	<u>1</u>	<u>94,692</u>	<u>2,064</u>	<u>-</u>	<u>-</u>
3. <u>Scott Kegley</u>	<u>RN</u>	<u>20</u>	<u>1</u>	<u>96,535</u>	<u>2,080</u>	<u>-</u>	<u>-</u>
4. _____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____	_____
13. <b>TOTAL EXPENSE (for columns E and G only)</b> .....				<b><u>\$ 241,429</u></b>		<b><u>\$ -</u></b>	

**SCHEDULE 46 - IDENTIFICATION OF EXPENSES FOR EMPLOYEE UNIQUE FRINGE BENEFITS**

**INSTRUCTIONS:** Unique fringe benefits are those fringe benefit items provided to only a few select employees and the expenses for such benefits may be reported in one or more cost centers of this report. Identify the unique fringe benefits provided to any individual employee by reporting the expenses related to the benefit and where the expenses are included in this cost report.

	<b>A. Name of Employee</b>	<b>B. Title</b>	<b>C. Describe Unique Fringe Benefit Item</b>	<b>D. Cost Ctr. Salary Exp.</b>	<b>E. Cost Ctr. Benefit Exp.</b>	<b>F. Schedule</b>	<b>G. Column</b>	<b>H. Line</b>	<b>I. Benefit Expense Amount</b>
1.	Kristina Hittman	Adm Dir	Bonus	44,990	5,212	23	1	5	4,150
2.	Scott Kegley	DON	Bonus	86,030	10,505	20	1	1	7,999
3.	Stacy Nies	Administrator	Bonus	80,584	14,108	26	1	1	14,195
4.									
5.									
6.									
7.									
8.									
9.									
10.									
11.									
12.									
13.									
14.									
15.									
16.									

### SCHEDULE 49 - PERCENTAGE OF OWNERSHIP

**INSTRUCTIONS:** List all individuals or entities that own 20% or more of the nursing home operation.

	Name of Individual or Entity	Percentage of Ownership
1.	HCP Properties, LP	100%
2.		
3.		
4.		
5.		

### SCHEDULE 50 - INTEREST IN OTHER MEDICAID PROVIDERS

**INSTRUCTIONS:** If the nursing home organization or any of its owners, administrators, officers, or any members of their immediate families are a separate provider or had an interest in any other provider in the Wisconsin Medicaid program, list the provider and explain the nature of the interest. Report interests that existed during the cost report period and/or existed up to the date of cost report submission to the Department. Include any other Wisconsin nursing home providers. Attach additional sheets if necessary.

	Name and City of Medicaid Provider	Type of medical Services Provided	Nature and Extent of Interest in Provider
1.	see attached	various	affiliate
2.			
3.			
4.			
5.			

## SCHEDULE 51 - MEDICAL SUPPLY REVENUES FROM MEDICARE PART B

**INSTRUCTIONS:** Wisconsin Medicaid policies and statutory authority on Medicare maximization include nursing homes billing Medicare for medical supplies and equipment under Medicare Part B. All Medicare-certified nursing homes should be billing Medicare Part B for services and supplies covered by the Medicare program. Nursing homes that are not Medicare certified may bill Medicare under Part B for medical supplies if they have separate Medicare certification as a durable medical equipment and supply vendor. Nursing home revenues from Medicare Part B should be included in the medical supply revenue on schedule 14 and must be identified on this schedule to properly account for third party payer revenues.

1. Does the nursing home bill Medicare for covered medical supplies under Medicaid Part B for Medicare eligible residents?.....  Yes  No
  
2. Is the nursing home Medicare certified?.....  Yes  No  
 If yes, submit a copy of worksheet D from the most recent Medicare Cost Report.
  
3. Does the nursing home have a separate Medicare certification to bill for equipment and supplies?.....  Yes  No
  
4. Medical supplies are billed to Medicare for the following types of residents (check all that apply) . . . . .  Private Pay  Title XIX (Medicaid)  Other
  
5. What were the Medicare Part B revenues for medical supplies? . . . . . \_\_\_\_\_
  
6. What were the costs related to the above medical supply revenues and where were they reported on this cost report?
  - a. Expense \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_
  - b. Expense \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_



## SCHEDULE 52 - MISCELLANEOUS MEDICAID NON-RATE REVENUES

**INSTRUCTIONS:** Wisconsin Medicaid provides for separate reimbursement for certain items not included in the daily rate or for additional reimbursement over and above the daily rate for certain services. For the items listed below, identify the revenue accrued by your facility for the services provided during the cost reporting period and where the revenues were reported in this cost report (should be included on schedules 14 through 18).

On lines 1 and 2, the amounts reported should only reflect the revenues in excess of the Medicaid daily rate for residents' levels of care and for which the related expenses are included in this cost report.

On line 2, report the amount of reimbursement from the Medicaid program for specialized services (active treatment) for mentally ill residents who were determined to be in need of such services by a level II pre-admission screening and annual resident review.

Medicaid Revenue Item	Revenue Amount	Location in Cost Report	
		Schedule	Line
1. Personalized durable medical equipment including Clinitron beds and motorized wheelchairs.....			
2. Specialized services for the mentally ill.....			
3a. Nurse aide training and competency evaluations - revenues from training aides for other facilities.....			
3b. Nurse aide training and competency evaluations - revenues from training aides for your own facilities.....			
3c. Nurse aide training and competency evaluations - revenues for performing competency evaluations.....			
<b>4. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES (sum 1-7) .....</b>	<b>\$ -</b>		

### SCHEDULE 53 - INCENTIVES - PRIVATE ROOM & PROPERTY

**PRIVATE ROOM INCENTIVE INSTRUCTIONS:** Based on the information provided in the cost report, your facility may qualify for the Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPRI) as explained in Section 2.720 of the Methods of Implementation. A facility may receive only one of the two private room incentives. A facility will qualify for the BPRI if it has exceptional Medicaid/Medicare utilization and at least 15% of the total beds are licensed for single occupancy. A facility will qualify for the RPRI if it has exceptional Medicaid/Medicare utilization and has replaced 100% of patient rooms after July 1, 2000.

Indicate if your facility is requesting a private room incentive

YES, my facility is requesting a private room incentive. If YES specify one and continue:  BPRI  RPRI

YES, I am requesting RPRI and my facility has replaced 100% of patient rooms after July 1, 2000.

NO, my facility is not requesting the BPRI or RPRI.

If your facility is requesting one of the incentives, you must complete the affidavit below and return it to the Department by July 1, 2017, to qualify for one of the private room incentives.

#### AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2017, to June 30, 2018, the \_\_\_\_\_ nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPRI) may be recouped retroactive to July 1, 2017, if the facility has charged Medicaid residents for private rooms during this period.

SIGNATURE -	Original Signature of Officer or Administrator of Nursing Home	Title	Date
-------------	--	-------	------

#### PROPERTY INCENTIVE:

Did the facility get approval for innovative property incentive on or after 7/1/12? See Sec. 3.655 of Methods of Implementation  YES  NO

ATTACH COPY OF INCENTIVE APPROVAL

Did the facility get approval prior to 7/1/12 for \$10 per patient day for "Innovative Area"? See Sec. 4.920 of Methods of Implementation  YES  NO

If YES to either question above - Complete the Following:

Date Approval Received: \_\_\_\_\_

Has Construction Begun?  YES  NO If YES, when did it begin? \_\_\_\_\_

Has construction been completed  YES  NO If completed, when was it completed? \_\_\_\_\_

Number of beds in Replacement Facility or "Innovative Area" 0

During this cost report period -

Number of Medicaid Fee For Service Patient days in Replacement Facility or "Innovative Area"? \_\_\_\_\_

Number of Medicaid Family Care Patient days in Replacement Facility or "Innovative Area"? \_\_\_\_\_

Number of Medicaid Partnership Patient days in Replacement Facility or "Innovative Area"? \_\_\_\_\_