

**WISCONSIN MEDICAID PROGRAM 2020 NURSING HOME COST REPORT****SCHEDULE 1: Facility & Preparer Information****SECTION A - FACILITY INFORMATION**

Facility Name Edenbrook of Oshkosh		Main Telephone Number 920-233-4011		Main Email Address gleb@edensiorhc.com	
Facility Street Address 1850 Bowens Street		City Oshkosh		State WI	Zip Code 54901
Contact Person Gleb Zarkh		Contact Telephone Number 773-825-3336		Contact Email Address gleb@edensiorcare.com	
Cost Report Period Start Date 1/1/2020	Cost Report Period End Date 12/31/2020	Medicaid Provider Number 100072206	National Provider Identifier (NPI) 1952833048	POP ID Number 669	
Administrator Cindy Anderson		Chief Financial Officer Gleb Zarkh		Where are the financial records of the nursing home located? Eden Senior Care	

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

Name and Title Wipfli LLP			Telephone Number 414-431-9335		
Address 10000 Innovation Drive, Suite 250			City Milwaukee		State WI
					Zip Code 53226
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 Notes

### SCHEDULE 3: General Information

1. Type of Medicaid certification (check all that apply)  (01) Nursing Facility  (10) ICF-IID

2. Type of ownership (check one)  (1) Proprietary  (2) Voluntary Non-Profit  (3) Governmental

3. County of facility winnebago County Code 70

4. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, complete Schedule S-F FB.  (1) Yes  (2) No

5. Fiscal Year Beginning Month Jan Fiscal Year Ending Month Dec

6. List the number of licensed beds at the beginning and end of your cost reporting period. Do not include restricted beds.

	DATE	BEDS
<u>Beds at Beginning of Cost Reporting Period</u>	<u>1/1/2020</u>	<u>120</u>
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.	<u>12/31/2020</u>	<u>120</u>

7. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements.  (1) Yes  (2) No

8. Check all related party transaction types for which expenses are reported.  (1) Related party lease of building  (2) Compensation to owners/family relation  
 (3) Interest expense on related party loans  (4) Other related party transactions

9. 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?  Yes  No

10. Asset depreciation schedules detailing amounts reported on Schedule 34 - Depreciation expenses must be submitted. Have copies been made and included with this cost report?  Yes  No

**11. 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.	<u>Edenbrook Oshkosh</u>	<u>3242</u>	<u>24</u>	<u>96</u>	<u>120</u>
2.					-
3.					-
4.	TOTAL .....		<u>24</u>	<u>96</u>	<u>120</u>

**SCHEDULE 4: Shared Services**

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 Nursing Home, 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. Apartment units, 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. Room and Board - Other, 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"/>
7. 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"/>
8. 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"/>
9. 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"/>
10. 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"/>
11. Adult 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"/>
12. Home Health	<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. 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"/>
14. 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"/>
15. 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"/>
16. 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"/>
17. Any items checked in this column	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

x = Yes      blank = No

**SCHEDULE 5 - NO LONGER USED**

**SCHEDULE 6: Total Patient Days**

<b>SECTION A - INHOUSE PATIENT DAYS</b>	<b>LEVEL OF CARE (LOC)</b>		
	<b>NON DD</b>	<b>DD</b>	<b>TOTAL</b>
1a. Medicaid (T-19) .....	6,266		6,266
1b. ICF-IID Medicaid (T-19) .....			-
1c. Family Care (T-19) .....	2,717		2,717
1d. Other Medicaid Managed Care (T-19) .....	120		120
1e. Hospice (T-19) .....	1,917		1,917
1f. Ventilator (T-19) .....			-
2a. Medicare (T-18) .....	1,617		1,617
2b. Medicare Advantage, for days covered as a Part A stay	682		682
3a. Private pay & Insurance .....	1,605		1,605
3b. Medicare Advantage, for days not covered as a Part A stay			-
3c. Hospice (Private pay & Insurance)	495		495
4. Other, Specify: <u>VA</u>	1,747		1,747
5. TOTAL INHOUSE PATIENT DAYS .....	17,166	-	17,166

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

<b>SECTION C - TOTAL PATIENT DAYS</b>	<b>NON DD</b>	<b>DD</b>	<b>TOTAL</b>
9. TOTAL DAYS .....	17,166	-	17,166

**SCHEDULE 7 - NO LONGER USED**

**SCHEDULE 8: Medicaid Bedhold Eligibility**

1. MONTH . . . . .	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	TOTAL
2. Days in Month . . . . .	31	29	31	30	31	30	31	31	30	31	30	31	366
3. Licensed Beds for Bed Hold Testing . . . . .	120	120	120	120	120	120	120	120	120	120	120	120	1,440
4. Occupancy Test: Row 2 x (Row 3 x 94%)	3,497	3,271	3,497	3,384	3,497	3,384	3,497	3,497	3,384	3,497	3,384	3,497	41,286
5. Inhouse patient days	1,645	1,581	1,684	1,586	1,566	1,530	1,425	1,286	1,392	1,248	1,070	1,153	17,166
6. Bed Hold days . . . . .	-	-	-	-	-	-	-	-	-	-	-	-	-
7. TOTAL DAYS . . . . .	1,645	1,581	1,684	1,586	1,566	1,530	1,425	1,286	1,392	1,248	1,070	1,153	17,166
	n/a	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	

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 9 - NO LONGER USED**



**SCHEDULE 10A: Summary of Changes to Equity**

1. Beginning Owners' Equity (from schedule 10) .....		<u>\$173,729</u>
2. Add		
Net income (from schedule 11, line 19)	<u>\$1,779,276</u>	
Owners' capital contribution	<u>70,785</u>	
County appropriation	<u>                    </u>	
Net decrease in accrued vacation, holiday and sick time	<u>168,496</u>	
Other, Specify: <u>add depreciation</u>	<u>48,413</u>	
Other, Specify: <u>                                    </u>	<u>                    </u>	
Total additions .....		<u>2,066,970</u>
3. Deduct		
Net loss (from schedule 11, line 19)	<u>( \$- )</u>	
Dividends and withdrawals	<u>(                      )</u>	
Net increase in accrued vacation, holiday and sick time	<u>(                      )</u>	
Other, Specify: <u>related party adjustment</u>	<u>( 53,152 )</u>	
Other, Specify: <u>                                    </u>	<u>(                      )</u>	
Total deductions .....		<u>( 53,152 )</u>
 4. ENDING OWNERS' EQUITY (schedule 10) .....		 <u>\$2,187,547</u>

## SCHEDULE 11: Summary of Revenues & Expenses

All values are automatically posted from other schedules.

### SECTION A - SUMMARY OF REVENUE

1. Daily patient service revenue . . . . .	schedule 14, lines 1-4	\$ 6,189,987
2. Service fees . . . . .	schedule 15, line 14A	3,017,021
3. Rent from outside medical providers . . . . .	schedule 15, line 14B	-
4. Other . . . . .	schedule 15, line 14C	-
5. Dietary revenues . . . . .	schedule 16, line 5A	112
6. Miscellaneous services and materials revenue . . . . .	schedule 16, line 16	1,120
7. Rental revenues . . . . .	schedule 17, line 22	-
8. Revenues from other major activities . . . . .	schedule 17, line 38	-
9. Sales to related organizations . . . . .	schedule 18, line 41	-
10. Investment revenue . . . . .	schedule 18, line 42	2,084
11. Gains (Losses) on disposal of assets . . . . .	schedule 18, line 43	-
12. Grants for government-subsidized employees . . . . .	schedule 18, line 44	-
13. Grants, contributions, donations . . . . .	schedule 18, line 45	-
14. Other revenue . . . . .	schedule 18, line 50	1,476,090
15. Subtract: deductions from revenues . . . . .	schedule 14, line 5	( 1,847,489 )
16. NET REVENUES . . . . .		\$ 8,838,925

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

17. Subtract: total expenses . . . . .	schedule 12, line 37	\$ ( 7,112,801 )
18. Add or subtract the amount to adjust related party transactions to cost . . . . .	schedule 42, line 15	53,152
19. NET INCOME OR LOSS . . . . .		\$ 1,779,276

### 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	<u>\$2,686,722</u>	20. Transportation . . . . .	S25, L14f	<u>\$18,181</u>
2. Laboratory & Radiology . . . . .	S21, L13a	<u>27,108</u>	21. Administrative service expense . . . . .	S26, L12	<u>1,279,689</u>
3. Respiratory . . . . .	S21, L13b	<u>-</u>	Other cost centers, Specify:		
4. Pharmacy . . . . .	S21, L13c	<u>177,762</u>	22. <u>Nurse Aide Training</u>	S27, L16a	
5. PT, OT and Speech . . . . .	S22, L13a	<u>462,718</u>	23. <u>Beauty/Barber Shop</u>	S27, L16b	
6. Dental . . . . .	S22, L13b	<u>-</u>	24. <u>0</u>	S27, L16c	
7. Physician . . . . .	S22, L13c	<u>26,400</u>	25. <u>0</u>	S27, L16d	
8. Social Services . . . . .	S23, L13a	<u>74,894</u>	26. <u>0</u>	S27, L16e	
9. Recreational Activities . . . . .	S23, L13b	<u>117,166</u>	UNASSIGNED EXPENSES		
10. Religious Services . . . . .	S23, L13c	<u>-</u>	27. Employee fringe benefit expense . . . . .	S28, L17	<u>385,714</u>
11. Volunteer Coordinator . . . . .	S24, L13a	<u>-</u>	28. Heating fuel and utility expense . . . . .	S29, L10	<u>155,630</u>
12. Ward Clerks . . . . .	S24, L13b	<u>-</u>	29. Interest on operating working capital loans .	S30, L6	<u>-</u>
13. Psychotherapy . . . . .	S24, L13c	<u>-</u>	30. Insurance expense . . . . .	S31, L9	<u>50,272</u>
14. Other . . . . .	S24, L13d	<u>-</u>	31. Amortization expense . . . . .	S32, L5	<u>-</u>
15. Dietary . . . . .	S25, L14a	<u>593,252</u>	32. Interest on plant asset loans . . . . .	S33, L15h	<u>-</u>
16. Plant Operations and Maintenance . . . . .	S25, L14b	<u>108,309</u>	33. Depreciation expense . . . . .	S34, L20c	<u>48,413</u>
17. Housekeeping . . . . .	S25, L14c	<u>129,198</u>	34. Expense on operating and non-cap.leases	S35, L14	<u>652,681</u>
18. Laundry and Linen . . . . .	S25, L14d	<u>47,179</u>	35. Expense on capitalized leases . . . . .	S36A, L5	<u>-</u>
19. Security . . . . .	S25, L14e	<u>1,165</u>	36. Property tax expense . . . . .	S37, L7	<u>70,348</u>
			<b>37. TOTAL EXPENSES FOR REPORT PERIOD</b>		<b><u>\$7,112,801</u></b>

(To schedule 11, line 17)

### SCHEDULE 13: Summary of Salary & Wage Expenses

All values are automatically posted from other schedules.

Cost Center and Schedule	Total Salary and Wage Expense	Cost Center and Schedule	Total Salary and Wage Expense
Daily patient service . . . . . S20, L1d	\$2,440,382	Dietary . . . . . S25, L1a	323,238
Laboratory & Radiology . . . . . S21, L1a	-	Plant operation / maintenance. . . . . S25, L1b	67,840
Respiratory . . . . . S21, L1b & 3b	-	Housekeeping . . . . . S25, L1c	113,035
Pharmacy . . . . . S21, L1c & 3c	-	Laundry and Linen . . . . . S25, L1d	30,463
PT, OT and Speech . . . . . S22, L1a & 3a	460,032	Security . . . . . S25, L1e	-
Dental . . . . . S22, L1b & 3b	-	Transportation . . . . . S25, L1f	11,033
Physician . . . . . S22, L1c & 3c	-	Administrative service . . . . . S26, L5	404,629
Social Services . . . . . S23, L3a	74,894	Nurse aide training . . . . . S27, L1a	-
Recreational Activities . . . . . S23, L3b	104,854	Beauty and barber . . . . . S27, L1b	-
Religious Services . . . . . S23, L3c	-	Other, Specify: <u>0</u> . . . . . S27, L1c	-
Volunteer Coordinator . . . . . S24, L3a	-	<u>0</u> . . . . . S27, L1d	-
Ward Clerks . . . . . S24, L3b	-	<u>0</u> . . . . . S27, L1e	-
Psychotherapy . . . . . S24, L1c & 3c	-	<b>TOTAL SALARY AND WAGE EXPENSE. . . . .</b>	<b>\$4,030,400</b>
Other . . . . . S24, L1d & 3d	-		

**SCHEDULE 14: Daily Patient Service Revenues**

**SECTION A - DAILY RATE CHARGES**

	Revenue
1. Medicare Daily Rate	\$1,555,405
2. Medicaid Daily Rate (including bed hold)	4,007,061
3. Private Pay	635,549
4. Medical Supplies, Other	(8,028)

**SECTION B - Deductions From Revenue**

5. TOTAL DEDUCTIONS FROM REVENUE ( 1,847,489 )

**SECTION C - TOTAL**

6. TOTAL DAILY PATIENT SERVICE REVENUE **\$4,342,498**

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**

7. Average Daily \$269.00

8. Facility Comment (Optional)

**SCHEDULE 15: Special Services Revenue**

SECTION A - SERVICE REVENUES	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory .....	\$16,418			
2. Radiology .....	573			
3. Pharmacy .....	166,276			
4. Physical therapy .....	2,410,475			
5. Speech/hearing therapy .....	70,050			
6. Occupational therapy .....	352,326			
7. Physician care .....				
8. Psychotherapy .....				
9. Respiratory therapy	1,540			
10. Social services .....				
11. Recreational activities .....				
12. Special duty nursing .....				
13. Other, Specify: <u>IV</u>	(637)			
14. TOTAL SPECIAL SERVICE REVENUE ..	<u>\$3,017,021</u>	<u>\$-</u>	<u>\$-</u>	

**SECTION B - THERAPY REVENUES**

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).			<u>\$2,832,851</u>
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)			<u>\$2,832,851</u>
18. If there is any variance between the totals reported on lines 16 and 17, explain.	<hr/>		
19. Are therapy services provided to individuals in addition to your nursing home residents?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount of revenue <u>\$1,175</u>
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount of revenue <u>\$1,278,150</u>
21. Did you charge rent to a rehabilitation agency or independent contractor?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	If yes, amount of revenue <u></u>

**SCHEDULE 16: Other Revenues**

**SECTION A - CAFETERIA AND DIETARY REVENUE**

1.	Donated and surplus food commodities .....	_____	Included in food supply expense for donated/surplus ..	_____
2.	Dietary supplies sold .....	_____	Cost of dietary supplies sold (if known) .....	_____
3.	Meals sold to employees (transfer to sched. 25A, line 10) .....	112		
4.	Meals On Wheels .....	_____		
5.	Other Meals Sold .....	_____		
<b>5a.</b>	<b>TOTAL DIETARY REVENUE .....</b>	<b>112</b>		

**SECTION B - MISCELLANEOUS SERVICES AND MATERIALS**

		<u>Expenses Directly Ascribable To Or Identifiable With Revenue</u>			
	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 .....	_____	_____	_____	_____
10.	Gift Shop .....	_____	_____	_____	_____
11.	Canteen and snack counter .....	_____	_____	_____	_____
12.	Vending machines .....	1,120	_____	_____	_____
13.	Sale of clothing .....	_____	_____	_____	_____
14.	Television and cable service .....	_____	_____	_____	_____
15.	Telephone and Internet .....	_____	_____	_____	_____
<b>16.</b>	<b>TOTAL MISCELLANEOUS SERVICES AND MATERIALS .....</b>	<b>1,120</b>			

**SCHEDULE 17: Other Revenues**

<b>SECTION A - RENTAL REVENUE</b>				
	<u>Revenue</u>	<u>Property Rented</u>	<u>Square Feet Rented</u>	<u>Services Provided</u>
18. Equipment rental . . . . .				
19. Rental of nursing home space . . . . .				
20. Rental of non-nursing home space . . . . .				
21. Parking . . . . .				
<b>22. TOTAL RENTAL REVENUES . . . . .</b>	<b>\$-</b>			

<b>SECTION B - REVENUE FROM MAJOR ACTIVITIES</b>		
	<u>Revenue</u>	<u>Total Billable Patient Days if revenue generated from activities</u>
23. Another Medicaid nursing home provider . . . . .		
24. Hospital . . . . .		
25. Non-Medicaid Nursing Home . . . . .		
26. Non-Medicaid CBRF . . . . .		
27. Apartment Units . . . . .		
28. Room and Board - Other . . . . .		
29. Adult Day Care . . . . .		
30. Home Health . . . . .		
31. Child Care . . . . .		
32. Clinic . . . . .		
33. _____		
34. _____		
35. _____		
36. _____		
37. _____		
<b>38. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES . . . . .</b>	<b>\$-</b>	

### SCHEDULE 18: Other Revenues

		<b>Revenue</b>
	SALES TO RELATED ORGANIZATIONS	
38.	_____	_____
39.	_____	_____
40.	_____	_____
41.	TOTAL SALES TO RELATED ORGANIZATIONS	\$-
42.	TOTAL INVESTMENT REVENUE .....	\$2,084
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS .....	_____
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES .....	_____
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS .....	_____
	OTHER REVENUES	
46.	other revenue	\$1,476,090
47.	_____	_____
48.	_____	_____
49.	_____	_____
50.	TOTAL OTHER REVENUES .....	\$1,476,090

**SCHEDULE 20: Daily Patient Service Expense**

<u>Salaries, Wages &amp; Purchased Serv.</u>	<u>A. Registered Nurses</u>	<u>B. Licensed Practical Nurses</u>	<u>C. Nurse Aides and Assistants</u>	<u>D. Total Expense or Hours</u>
1. TOTAL SALARY AND WAGE EXPENSE	\$1,003,954	\$278,138	\$1,158,290	\$2,440,382
2. TOTAL SALARY AND WAGE HOURS	30,005 hrs.	9,962 hrs.	65,150 hrs.	\$105,117
3. EXPENSE FOR PURCHASED SERVICES	\$50,530	\$14,059	\$4,958	\$69,547
AVERAGE WAGE PER HOUR	\$33.46	\$27.92	\$17.78	\$23.22
<b>NURSING AND INCONTINENCY SUPPLIES</b>				
4. Catheters, Incontinency Supplies (including purchased laundry service)				\$32,078
<b>OXYGEN</b>				
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental				3,983
<b>OTHER</b>				
6. Other medical supplies, personal comfort supplies and minor medical equipment				66,264
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				10,744
8. <u>other nursing expense</u>				63,724
9. _____				
10. <b>TOTAL DAILY PATIENT SERVICE EXPENSE</b>				<b>\$2,686,722</b>

### SCHEDULE 21: Special Service Expenses

SECTION A - SALARY AND WAGES	TYPE OF SERVICE		
	<u>A. Laboratory &amp; Radiology</u>	<u>B. Respiratory</u>	<u>C. Pharmacy</u>
1. Expense for hours worked - Billable			
2. Number of hours worked - Billable			
3. Expense for hours worked - Non-billable	\$-		
4. Number of hours worked - Non-billable	hrs.		
5. TOTAL SALARY AND WAGE EXPENSE	\$-	\$-	\$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	\$27,108		\$2,681
7. Expense for purchased service - Non billable	\$-		
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. Pharmacy - legend drugs Billable	\$-	\$-	159,029
9. Pharmacy - over the counter drugs Billable	\$-	\$-	16,052
10. Supply and Other			
11. _____			
12. _____			
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES	<b>\$27,108</b>	<b>\$-</b>	<b>\$177,762</b>
14. TOTAL HOURS	<b>hrs.</b>	<b>hrs.</b>	<b>hrs.</b>

### 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. ....	\$460,032		
2. Number of hours worked - Billable. ....	14,025 hrs.		
3. Expense for hours worked - Non-billable. ....			
4. Number of hours worked - Non-billable. ....			
5. TOTAL SALARY AND WAGE EXPENSE	\$460,032	\$-	\$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable. ....			\$26,400
7. Expense for purchased service - Non billable. ....			
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. supplies	2,686		
9. _____			
10. _____			
11. _____			
12. _____			
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES. ....	\$462,718	\$-	\$26,400
14. TOTAL HOURS. ....	14,025 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	\$74,894	\$104,854	
4. Number of hours worked - Non-billable	3,573 hrs.	4,930 hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	\$74,894	\$104,854	\$-
<b>SECTION B - PURCHASED SERVICES</b>			
6. Expense for purchased service - Billable	\$-	\$-	\$-
7. Expense for purchased service - Non billable		\$315	
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>			
8. <u>supplies</u>		\$11,997	
9.			
10.			
11.			
12.			
<b>SECTION D - TOTAL</b>			
13. TOTAL EXPENSES	\$74,894	\$117,166	\$-
14. TOTAL HOURS	3,573 hrs.	4,930 hrs.	hrs.

### SCHEDULE 24: 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. Expense for purchased service - Non billable				
<b>SECTION C - SUPPLY AND OTHER EXPENSE</b>				
8.				
9.				
10.				
11.				
12.				
<b>SECTION D - TOTAL</b>				
13. TOTAL EXPENSES	\$-	\$-	\$-	
14. TOTAL HOURS	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	\$323,238	\$67,840	\$113,035	\$30,463		\$11,033
2. NUMBER OF HOURS WORKED	21,325 hrs.	2,812 hrs.	8,562 hrs.	2,436 hrs.		1,003 hrs.
<b>SECTION B - DIETICIAN CONSULTANT</b>						
3. Dietician consultant expense	\$33,909	\$-	\$-	\$-	\$-	\$-
<b>SECTION C - OUTSIDE SERVICE</b>						
4. purchased services		\$15,820			\$1,165	\$7,148
5. _____						
6. _____						
7. _____						
8. TOTAL OUTSIDE SERVICE EXPENSES	\$-	\$15,820	\$-	\$-	\$1,165	\$7,148
<b>SECTION D - SUPPLY AND OTHER EXPENSE</b>						
9. supplies	\$236,105	\$24,649	\$16,163	\$16,716		
10. _____						
11. _____						
12. _____						
13. _____						
<b>SECTION E - TOTAL</b>						
14. TOTAL EXPENSES .....	<b>\$593,252</b>	<b>\$108,309</b>	<b>\$129,198</b>	<b>\$47,179</b>	<b>\$1,165</b>	<b>\$18,181</b>

**SCHEDULE 25A: Support Services Expense Allocations**

**SECTION A - ALLOCATION OF DIETARY EXPENSES**

1. Total dietary expenses (from Schedule 25, Line 14a)	<u>\$593,252</u>
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) . . . . .	<u>\$-</u>
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2)	<u>\$-</u>
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below)	<u>\$593,252</u>

	A. Total	B. Residents'	C. Employees'	D. Meals on	E. Other	F. Other
		Meals	Meals	Wheels		
6. Meals served	<u>82,101</u>	<u>82,101</u>				
7. Ratio to total meals served to 4 decimals	<u>1.0000</u>	<u>1.0000</u>				
8. DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	<u>\$593,252</u> <small>From line 5</small>	<u>\$593,252</u> <small>8A x 7B</small>	<u>\$-</u> <small>8A x 7C</small>	<u>\$-</u> <small>8A x 7D</small>	<u>\$-</u> <small>8A x 7E</small>	<u>\$-</u> <small>8A x 7F</small>
9. Food products provided to employees without charge (from line 2)			<u>\$-</u>			
10. Deduct revenue from meals sold to employees (from schedule 16, line 3)			<u>112</u>			
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C)			<u>\$(112)</u>			

**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	<u>60,981</u>	<u>60,981</u>				
13. Ratio to total square feet to 4 decimals . .	<u>1.0000</u>	<u>1.0000</u>				
14. TOTAL PATIENT OP/MAINT EXP. ALLOC. <small>From S25, L18</small>	<u>\$108,309</u> <small>From S25, L18</small>	<u>\$108,309</u> <small>14A x 13B</small>	<u>\$-</u> <small>14A x 13C</small>	<u>\$-</u> <small>14A x 13D</small>	<u>\$-</u> <small>14A x 13E</small>	<u>\$-</u> <small>14A x 13F</small>

**SCHEDULE 25B: Support Services Expense Allocations**

**SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES**

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
15. Square feet or hours of service provided	60,981	60,981			
16. Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17. TOTAL HOUSEKEEPING EXP. ALLOC.	\$129,198	\$129,198	\$-	\$-	\$-
	<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**

**Non-Nursing Home Areas Receiving Laundry/Linen Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
18. Pounds of laundry processed	60,981	60,981			
19. Ratio to total pounds to 4 decimals . . . . .	1.0000	1.0000			
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	\$47,179	\$47,179	\$-	\$-	\$-
	<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**

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
21. Total square feet of area	60,981	60,981			
22. Ratio to total square feet to 4 decimals . .	1.0000	1.0000			
23. TOTAL SECURITY EXPENSE ALLOC.	\$1,165	\$1,165	\$-	\$-	\$-
	<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**

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

	<u>A. Total</u>	<u>B. Nursing Home Area</u>			
24. Alloc. Basis, Specify: <u>square feet</u>	60,981	60,981			
25. Ratio to total alloc. basis to 4 decimals	1.0000	1.0000			
26. TOTAL TRANS. EXPENSE ALLOC.	\$18,181	\$18,181	\$-	\$-	\$-
	<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**

		<b>Expenses</b>
<b>SECTION A - SALARY AND WAGES</b>		
1.	General Admin & Accounting	\$310,611
2.	Medical Records	46,651
3.	Central Supply	
4.	Scheduling	47,367
5.	Total Salary and Wage Expense	\$404,629
<b>SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS</b>		
6.	Home office costs allocated to facility	
	Name of home office _____	
	From (date) _____	
	Through (date) _____	
7.	County costs allocated to facility	
<b>SECTION C - NON-SALARY EXPENSES</b>		
8.	Purchased services - legal	\$(7,805)
9.	Licensed bed assessment	224,400
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	658,465
<b>SECTION D - TOTAL</b>		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	<b>\$1,279,689</b>

**SCHEDULE 26ATT: Administrative Service Expenses - Other Non-Salary**

Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1. <u>medical records</u>	\$82
2. <u>supplies</u>	6,311
3. <u>advertising</u>	6,401
4. <u>IT</u>	66,143
5. <u>payroll processing</u>	15,812
6. <u>Cable/internet</u>	36,775
7. <u>dues and subscriptions</u>	5,363
8. <u>education and seminars</u>	1,535
9. <u>office expense</u>	22,115
10. <u>bank charges and penalties</u>	8,342
11. <u>professional fees</u>	458,236
12. <u>license and permits</u>	927
13. <u>bad debts</u>	27,267
14. <u>other admin</u>	3,156
15. _____	
16. <b>TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) .....</b>	<b>\$658,465</b>

**SCHEDULE 26: Related Party Administrative Service Expenses**

		Expenses
<b>SECTION A - SALARY AND WAGES</b>		
1.	General Admin & Accounting	_____
2.	Medical Records	_____
3.	Central Supply	_____
4.	Scheduling	_____
5.	Total Salary and Wage Expense	\$-
<b>SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS</b>		
6.	Home office costs allocated to facility	_____
	Name of home office	_____
	From (date)	_____
	Through (date)	_____
7.	County costs allocated to facility	_____
<b>SECTION C - NON-SALARY EXPENSES</b>		
8.	Purchased services - legal	_____
9.	Licensed bed assessment	_____
10.	Contractual management fees	_____
11.	Total other non-salary (from schedule 26 attachment)	-
<b>SECTION D - TOTAL</b>		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	\$-

### SCHEDULE 26ATTRP: Related Party Administrative Service Expenses - Other Non-Salary

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. _____	_____
16. <b>TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11)</b> . . . . .	<b>\$-</b>

**SCHEDULE 26B: Allocation of Administrative Expenses**

1. Total Admin. Service Expense (S26, 12) \$1,279,689

**SECTION A - DIRECT EXPENSES**

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

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider			
2. all admin	<u>\$(1,279,689)</u>	<u>\$1,279,689</u>			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE . . . . .	<u>\$(1,279,689)</u>	<u>\$1,279,689</u>			
16. NET UNASSIGNED EXPENSE	<u>\$-</u>				

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

	A. Total	B. NH Provider			
17. Allocation basis amounts . . . . .	-				
18. Ratio to total basis to 4 decimals . . . . .	1.0000	1.0000			
19. UNASSIGNED ADMIN. EXP. ALLOC . . . . .	\$-	-	-	-	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE . . . . .	<u>\$1,279,689</u>	<u>\$1,279,689</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

**SCHEDULE 27: Other Cost Centers**

**SECTION A - SALARY AND WAGES**

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
1. TOTAL SALARY AND WAGE EXPENSE	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
2. NUMBER OF HOURS WORKED	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>

**SECTION B - NON-SALARY EXPENSES**

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>-</u>	<u>-</u>	<u>-</u>
3. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
4. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
5. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
6. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
7. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
8. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
9. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
10. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
11. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
12. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
13. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
14. _____	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>
15. <b>TOTAL NON-SALARY EXPENSES</b>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>	<u>\$-</u>

**SECTION C - TOTAL**

	<u>A. Nurse Aide Training</u>	<u>B. Beauty/Barber Shop</u>	<u>-</u>	<u>-</u>	<u>-</u>
16. <b>TOTAL EXPENSES</b> .....	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>	<u>_____</u>

**SCHEDULE 28: Fringe Benefits**

Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1. Employer's share of F.I.C.A.		\$297,247
2. State unemployment compensation		25,854
3. Federal unemployemnt compensation		6,337
4. Worker's compensation insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	37,199
5. Health, Dental & Vision Insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	16,062
6. Life and disability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	(898)
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 type="checkbox"/> No	
9. Post-Employment Physicals and Vaccines		
10. Uniforms		
11. <u>other fringes</u>		3,913
12. _____		
13. _____		
14. _____		
15. TOTAL PAID ON BEHALF OF EMPLOYEEES		<b>\$385,714</b>
16. Expense for special salary or wage payments to employees not included elsewhere		
<input type="checkbox"/> Christmas bonus		
<input type="checkbox"/> Longevity bonus		
<input type="checkbox"/> Productivity bonus		
<input type="checkbox"/> Bonuses to owners and immediate family relations, Specify:		
<input type="checkbox"/> Other, Specify:		
17. <b>TOTAL FRINGE BENEFIT EXPENSE</b>		<b>\$385,714</b>

### SCHEDULE 28B: Fringe Benefits - Self-Funded

Type of Self-Funded Expenses	Worker's Compensation Insurance	Health, Dental and Vision Insurance	Life and Disability Insurance	Wage Continuation Insurance	Pension and Deferred Compensation Plans
Checked as self-funded on Sch 28?					
1 Actual Claims Paid					
2 Premium costs for re-insurance (stop loss) policies purchased from an unrelated party					
3 Costs paid to administer the self insurance plan not reported elsewhere in the cost report					
4 Costs paid to an independent unrelated trustee to manage the self-insurance plan					
5 Costs paid to an unrelated actuary to perform actuarial determinations					
6 Employee Contributions					
7 Proceeds from re-insurance (stop loss) policies, dividend proceeds, and audit adjustment cost decreases or (increases)					
8 Investment income earned by the self insurance fund					
9 Gain on the sale of self insurance fund securities					
10 Total allowable self-funded fringe benefit expenses (add lines 1 thru 5 and subtract lines 6 thru 9)	\$-	\$-	\$-	\$-	\$-

**SCHEDULE 29: Heating and Utility Service Expenses**

**SECTION A - ACCRUED EXPENSE BY TYPE**

	<u>Accrued Expense</u>	<u>Expense by Type</u>	<u>Accrued Expense</u>
1. Fuel oil		6. Water and sewer utility charges	58,919
2. Natural gas	8,955	7. Purchased steam	
3. L.P. gas		8. _____	
4. Coal		9. _____	
5. Electricity	87,756	<b>10. TOTAL FUEL AND UTILITY EXPENSE . . .</b>	<b>155,630</b>

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

	<u>A. Total</u>	<u>B. NH Area</u>	<u>C. Emp. Unique Fringe Ben. Area</u>	<u>Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.</u>		
11. Total square feet for areas	62,321	60,981	1,340			
12. Ratio to total square feet to 4 decimals	1.0000	0.9785	0.0215			
<b>13. TOTAL ALLOC. FUEL/UTIL. EXPENSE</b>	<b>155,630</b>	<b>\$152,284</b>	<b>\$3,346</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: Working Capital Loans

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

### SCHEDULE 31: Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1. Property insurance on building and contents	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$8,271
2. Automobile insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Liability insurance	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	42,001
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. 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>\$50,272</b>

### SCHEDULE 32: Amortized Expenses

A. Bond Issue	B. Sch. 33 Line Number	C. Original Amount	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 30RP: Related Party Working Capital Loans

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

### SCHEDULE 31RP: Related Party Accrued Insurance Expenses

A. Type of Insurance Coverage	B. Self-Funded?	C. 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 32RP: Related Party Amortized Expenses

A. Bond Issue	B. Sch 33RP Line Number	C. Original Amount	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: 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 1/1/2020	E. 6Mo.date 6/30/2020	F. End date 12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	\$-	\$-	_____	_____	_____	
2. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
3. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
4. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
5. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
6. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
7. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	
<b>15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).....</b>				<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	<b>\$-</b>	

**SCHEDULE 33P2: Plant Asset Loans- Page 2**

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		
				1/1/2020	6/30/2020	12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
8. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
9. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
10. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
11. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
12. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
13. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
14. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____

SEE SCHEDULE 33 FOR TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE OF SCHEDULE 33, INCLUDING PAGE 2

**SCHEDULE 33RP: Related Party 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	E. 6Mo. date	F. End date		
				1/1/2020	6/30/2020	12/31/2020		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1. Name <u>WFF</u> Related party? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Purpose <u>Facility acquisition/mortgage</u>	<u>Jul-19</u>	<u>Jul-22</u>	<u>\$5,204,771</u>	<u>\$5,204,771</u>	<u>\$5,383,336</u>	<u>\$5,383,336</u>	<u>5.25%</u>	<u>\$317,665</u>
2. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
3. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
4. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
5. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
6. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
7. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
<b>15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).....</b>				<b><u>\$5,204,771</u></b>	<b><u>\$5,383,336</u></b>	<b><u>\$5,383,336</u></b>		<b><u>\$317,665</u></b>

**SCHEDULE 33P2RP: Related Party Plant Asset Loans - Page 2**

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 1/1/2020 Begin Bal.	E. 6Mo.date 6/30/2020 6 Mo. Bal.	F. End date 12/31/2020 End Bal.		
8. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
9. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
10. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
11. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
12. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
13. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____
14. Name _____ Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No Purpose _____	_____	_____	_____	_____	_____	_____	_____	_____

SEE SCHEDULE 33- RELATED PARTY FOR TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE OF SCHEDULE 33, INCLUDING PAGE 2

**SCHEDULE 34: Depreciation Expenses**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2020</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2020</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	-		( )	\$-
2. Land Improvements	5,400	14,275	( )	19,675
3. Buildings	10,728		( )	10,728
4. Leasehold Improvements	303,030	27,498	( )	330,528
5. Fixed equipment	-		( )	-
6. Moveable equipment	124,478	10,570	( )	135,048
7. Transportation vehicles	-		( )	-
8. _____			( )	-
9. _____			( )	-
10. TOTAL CAPITALIZED COST . .	<b>\$443,636</b>	<b>\$52,343</b>	<b>( \$-</b> )	<b>\$495,979</b>

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

	A. Depreciation	Begin Date <u>1/1/2020</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2020</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements		\$1,406	\$824	( )	\$2,230
12. Buildings		1,223	957	( )	2,180
13. Leasehold Improvements		51,454	30,900	( )	82,354
14. Fixed equipment		-		( )	-
15. Moveable equipment		23,987	15,732	( )	39,719
16. Transportation vehicles		-		( )	-
17. _____				( )	-
18. _____				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<b>\$78,070</b>		<b>( \$-)</b>	<b>\$126,483</b>
<b>20. TOTAL DEPRECIATION EXPENSE</b>			<b>\$48,413</b>		
21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period			\$6,395		

**SCHEDULE 34RP: Related Party Depreciation Expenses**

**SECTION A - CAPITALIZED HISTORICAL COST**

	Begin Date <u>1/1/2020</u>	C. Additions During Report	D. Disposals During Report	End Date <u>12/31/2020</u>
	B. Beginning Balance	Period	Period	E. Ending Balance
1. Land	\$322,967		( )	\$322,967
2. Land Improvements	-		( )	-
3. Buildings	3,634,958		( )	3,634,958
4. Leasehold Improvements	-		( )	-
5. Fixed equipment	-		( )	-
6. Moveable equipment	348,297		( )	348,297
7. Transportation vehicles	-		( )	-
8. _____			( )	-
9. _____			( )	-
10. TOTAL CAPITALIZED COST . .	<b>\$4,306,222</b>	<b>\$-</b>	<b>( \$-</b> )	<b>\$4,306,222</b>

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

	A. Depreciation	Begin Date <u>1/1/2020</u>	C. Depreciation Exp.	D. Removal of Accum.	End Date <u>12/31/2020</u>
	Method, Lives Used	B. Beginning Balance	During Report Period	Deprec. On Disposals.	E. Ending Balance
11. Land Improvements		\$-		( )	\$-
12. Buildings		75,728	181,748	( )	257,476
13. Leasehold Improvements		-		( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment		29,025	69,659	( )	98,684
16. Transportation vehicles		-		( )	-
17. _____				( )	-
18. _____				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		<b>\$104,753</b>		<b>( \$-</b> )	<b>\$356,160</b>
20. TOTAL DEPRECIATION EXPENSE			<b>\$251,407</b>		

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

### SCHEDULE 35: Lease Expenses

**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. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
1. <u>Oshkosh Realty Co</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>May-19</u>	<u>Building</u>	<u>\$622,224</u>
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. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
4. <u>acceleerated care plus</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>medical equipment</u>	<u>\$17,045</u>
5. <u>care one</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>medical equipment</u>	<u>2,124</u>
6. <u>synapse</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>medcial equipment</u>	<u>8,726</u>
7. <u>northwest</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>medical equipment</u>	<u>(790)</u>
8. <u>culligan</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>water softener</u>	<u>3,265</u>
9. <u>mineral spring</u>	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		<u>Jan-20</u>	<u>water cooler</u>	<u>87</u>
10. _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No				
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						<u><b>\$652,681</b></u>
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### SCHEDULE 36A: Capitalized Leases

#### SECTION A - CAPITALIZED LEASE INFORMATION

#### Lease Expense

1. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

1a. Amortization of capitalized lease value \_\_\_\_\_  
 1b. Interest expense on capital lease obligation \_\_\_\_\_  
 1c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 1d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

2. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

2a. Amortization of capitalized lease value \_\_\_\_\_  
 2b. Interest expense on capital lease obligation \_\_\_\_\_  
 2c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 2d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

3. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

3a. Amortization of capitalized lease value \_\_\_\_\_  
 3b. Interest expense on capital lease obligation \_\_\_\_\_  
 3c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 3d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

4. Name of lessor \_\_\_\_\_  
 Is lessor a related party? . . . . .  Yes  No  
 Beginning Lease Date \_\_\_\_\_  
 Ending Lease Date \_\_\_\_\_  
 Is this a lease purchase agreement?  Yes  No  
 Description of leased property \_\_\_\_\_

4a. Amortization of capitalized lease value \_\_\_\_\_  
 4b. Interest expense on capital lease obligation \_\_\_\_\_  
 4c. Accrued contingent lease payments for period . . . \_\_\_\_\_  
 4d. SUBTOTAL LEASE EXPENSE \_\_\_\_\_

5. **TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD** . . . . . **\$-**

### SCHEDULE 36B: Capitalized Leases

#### 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** ..... **\_\_\_\_\_ \$-**

### SCHEDULE 37: Property Taxes

**SECTION A - FOR ALL PROVIDERS**

1. 2020 Real Estate Tax Bill

Expense

\$70,348

2. 2020 Personal Property Tax Bill

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. 2018 or 2019?

Yes, explain below

No

Tax year \_\_\_\_\_

Amount still outstanding \_\_\_\_\_

Tax year \_\_\_\_\_

Amount still outstanding \_\_\_\_\_

**SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY**

4. 2020 Municipal Service Fee or Payment in Lieu of Taxes

Expense

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

Cost center name \_\_\_\_\_

Schedule number \_\_\_\_\_

Line number \_\_\_\_\_

Amount reported \_\_\_\_\_

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

**7. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE .....**

**\$70,348**

### SCHEDULE 37RP: Related Party Property Taxes

**SECTION A - FOR ALL PROVIDERS**

Expense

1. 2020 Real Estate Tax Bill

2. 2020 Personal Property Tax Bill

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. 2018 or 2019?  Yes, explain below  No

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

**SECTION B - FOR TAX-EXEMPT PROVIDERS ONLY**

Expense

4. 2020 Municipal Service Fee or Payment in Lieu of Taxes

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

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

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

**TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE** .....

**\$-**

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**SCHEDULE 38 - NO LONGER USED**

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**SCHEDULE 39 - NO LONGER USED**

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**NURSING HOME COST REPORT SCHEDULES 38, 39**

**SCHEDULE 40: Allocated Property Expenses**

	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities				
			C.	D.	E.
<b>SECTION A - DIRECT PROPERTY EXP.</b>	<b>A. Total From Sched.</b>	<b>B. NH Service Area</b>			
1. Property insurance (s31)	\$8,271				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	-				
4. Plant asset interest expense (s33)	-				
5. Depreciation land improvements (s34)	824				
6. Depreciation buildings (s34)	957				
7. Depreciation leasehold improve. (s34)	30,900				
8. Depreciation fixed equipment (s34)	-				
9. Depreciation moveable equip. (s34)	15,732				
10. Depreciation transportation veh. (s34)	-				
11. Depreciation other (s34)	-				
12. Expense on operating leases (s35)	652,681				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	70,348				
15. TOTAL EXPENSE	\$779,713	\$-			
16. Less total directly assigned property exp.	\$-				
17. <b>NET UNASSIGNED/INDIRECT PROP. . . . .</b>	<b>\$779,713</b>				
<b>SECTION B - NON-SALARY EXPENSES</b>	<b>A. Total From Sched.</b>	<b>B. NH Area</b>			
18. Square feet of service's building area	32,321	30,981	1,340		
19. Ratio to total square feet to 4 decimals	1.0000	0.9585	0.0415		
20. Indirect property expense allocation	\$779,713 (from 17A)	747,355 20A x 19B	32,358 20A x 19C	- 20A x 19D	- 20A x 19E
<b>SECTION C - TOTAL</b>	<b>A. Total From Sched.</b>	<b>B. NH Area</b>			
21. <b>TOTAL PROP. EXP. FOR EACH AREA</b>	<b>\$779,713</b> 17A + 20 A	<b>\$747,355</b> 15B + 20B	<b>\$32,358</b> 15C + 20C	<b>\$-</b> 15D + 20D	<b>\$-</b> 15E + 20E

### SCHEDULE 41: Paid Time-Off Expenses

**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. Capitalize amounts over \$750 and at least 3 year of useful life.

3. Volunteer and unpaid employees - briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report  
n/a

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

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

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

**SCHEDULE 42: Identification of Expenses from Transactions with Related Parties and Organizations**

**SECTION A - RELATED PARTY LEASES**

Location and Amount of Expense Included in This Cost Report

<u>A. Description of Expense Item</u>	<u>B. Cost Ctr.</u>	<u>C. Schedule</u>	<u>D. Column</u>	<u>E. Line</u>	<u>F. Net Expense</u>
1. Total related party lease expense	property	35	g	1	\$(622,224)
2. Insurance expense					
3. Amortization deferred expense					
4. Interest expense	property	33rp	g	1	317,665
5. Depreciation expense	property	34rp	c	20	251,407
6. Property tax expense					
7. _____					
8. _____					
9. SUBTOTAL FOR RELATED PARTY LEASES					\$(53,152)

**SECTION B - OTHER RELATED PARTY TRANSACTIONS**

10. _____					
11. _____					
12. _____					
13. _____					
14. _____					
15. TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18) . . . . .					\$(53,152)

**SECTION C - IDENTIFICATION OF RELATED PARTIES**

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

Oshkosh Realty Company

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHEDULE 43: Identification of Expenses Not Related to Patient Care**

A. Description of Expense Item	Amount	Cost Ctr.	Location of Expense in Cost Report		
			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					
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: _____					
22. Other - describe: _____					

**SCHEDULE 43A - NO LONGER USED**

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**SCHEDULE 44 - NO LONGER USED**

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**SCHEDULE 45: Distribution of Compensation Expenses to Key Personnel  
Submit as a separate supporting document.**

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**SCHEDULE 46: Identification of Expenses for Employee Unique Fringe Benefits**

<u>A. Name of Employee</u>	<u>B. Title</u>	<u>C. Describe Unique Fringe Benefit Item</u>	<u>D. Cost Ctr. Salary Exp.</u>	<u>E. Cost Ctr. Benefit Exp.</u>	<u>F. Schedule</u>	<u>G. Column</u>	<u>H. Line</u>	<u>I. Benefit Expense Amount</u>
1. _____	_____	_____	_____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____	_____	_____	_____
16. _____	_____	_____	_____	_____	_____	_____	_____	_____

**SCHEDULE 49: Percentage of Ownership**

	<b>Name of Individual or Entity</b>	<b>Percentage of Ownership</b>
1.	Oshkosh Realty Company	100%
2.		
3.		
4.		
5.		

**SCHEDULE 50: Interest in Other Providers**

	<b>Name and City of Medicaid Provider</b>	<b>Type of Medical Services Provided</b>	<b>Nature and Extent of Interest in Provider</b>
1.			
2.			
3.			
4.			
5.			

**SCHEDULE 51 - NO LONGER USED**

**SCHEDULE 52: Miscellaneous Medicaid Non-Rate Revenues**

<b>Medicaid Revenue Item</b>	<b>Revenue Amount</b>	<b>Location in Cost Report</b>	
		<b>Schedule</b>	<b>Line</b>
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 .....</b>	<b>\$-</b>		

**SCHEDULE 53: Incentives – Private Room & Property**

**SECTION A - PRIVATE ROOM INCENTIVE**

Indicate if your facility is requesting a private room incentive

Yes, my facility is requesting the private room incentive.

<b>AFFIDAVIT</b>		
<p>I HEREBY ATTEST and affirm that from July 1, 2021, to June 30, 2022, 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 Private Room Incentive                      may be recouped retroactive to July 1, 2021, if the facility has charged Medicaid residents for private rooms during this period.</p>		
<b>SIGNATURE -</b>	Original Signature of Officer or Administrator of Nursing Home	Date

**SECTION B - PROPERTY INCENTIVE**

1. Did the facility get approval for the Innovative Area Incentive prior to 7/1/12?

YES

2. Did the facility get approval for the Innovative Area Incentive on or after 7/1/12?

YES