WISCONSIN MEDICAID PROGRAM 2020 NURSING HOME COST REPORT

SCHEDULE 1: Facility & Preparer Information

SECTION A - FACILITY INFORMATION

Facility Name	Main Telephone Number	Main Email Address	
Peabody Manor	920-454-4199	Debra.VanPay@thedacare.org	
Facility Street Address	**City**	**State**	**Zip Code**
2500 S. Heritage Woods Dr.	Appleton	WI	54915

Contact Person	Contact Telephone Number	Contact Email Address
Debra VanPay	920-454-4199	Debra.VanPay@thedacare.org

Cost Report Period Start Date	Cost Report Period End Date	Medicaid Provider Number	National Provider Identifier (NPI)	POP ID Number
1/1/2020	12/31/2020	20188400	1326079757	733

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Chris Van Asten	Mark Thompson	3 Neenah Center, 4th Floor, Neenah, WI 54956

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

Name and Title		Telephone Number	
Deb Emerson, Principal		317-569-6230	
Address	**City**	**State**	**Zip Code**
9365 Counselors Row, Suite 200	Indianapolis	IN	46240
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

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 2: Provider Notes

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 3: General Information

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

2. Type of ownership (check one) [X] (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. [X] (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.

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.

	DATE	BEDS
Beds at Beginning of Cost Reporting Period	1/1/2020	58
Beds at End of Cost Reporting Period	12/31/2020	58

7. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements. [X] (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? [X] 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? [X] 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.	ThedaCare, Inc. dba Peabody Manor	2622	50	8	58
2.					-
3.					-
4.	TOTAL		50	8	58

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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:	☐	☐	☐	☐	☐	☐	☐	☐
2. Hospital, Name of hospital: Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
3. Non-Medicaid Nursing Home, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
4. Non-Medicaid CBRF, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
5. Apartment units, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
6. Room and Board - Other, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
7. Therapy services, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
8. Pharmacy	☐	☐	☐	☐	☐	☐	☐	☐
9. Laboratory or radiology services	☐	☐	☐	☐	☐	☐	☐	☐
10. Rental of building space	☐	☐	☐	☐	☐	☐	☐	☐
11. Adult Day Care	☐	☐	☐	☐	☐	☐	☐	☐
12. Home Health	☐	☐	☐	☐	☐	☐	☐	☐
13. Food catering services (meals on wheels, etc.)	☐	☐	☐	☐	☐	☐	☐	☐
14. Child care	☐	☐	☐	☐	☐	☐	☐	☐
15. Clinic	☐	☐	☐	☐	☐	☐	☐	☐
16. Other, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
17. Any items checked in this column x = Yes blank = No	☐	☐	☐	☐	☐	☐	☐	☐

SCHEDULE 5 - NO LONGER USED

SCHEDULE 6: Total Patient Days

SECTION A - INHOUSE PATIENT DAYS

		LEVEL OF CARE (LOC) NON DD	DD	TOTAL
1a.	Medicaid (T-19)	6,466		6,466
1b.	ICF-IID Medicaid (T-19)			-
1c.	Family Care (T-19)			-
1d.	Other Medicaid Managed Care (T-19)			-
1e.	Hospice (T-19)	1,205		1,205
1f.	Ventilator (T-19)			-
2a.	Medicare (T-18)	1,782		1,782
2b.	Medicare Advantage, for days covered as a Part A stay	2,959		2,959
3a.	Private pay & Insurance	2,365		2,365
3b.	Medicare Advantage, for days not covered as a Part A stay			-
3c.	Hospice (Private pay & Insurance)	194		194
4.	Other, Specify: Medicaid Pending(MP)	113		113
5.	TOTAL INHOUSE PATIENT DAYS	15,084	-	15,084

SECTION B - BED HOLD DAYS
Charged Bed Hold Days Only

		NON DD	DD	TOTAL
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	-	-	-

SECTION C - TOTAL PATIENT DAYS

		NON DD	DD	TOTAL
9.	**TOTAL DAYS**	**15,084**	**-**	**15,084**

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SCHEDULE 7 - NO LONGER USED

SCHEDULE 8: Medicaid Bedhold Eligibility

		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**
1.	MONTH													
2.	Days in Month	31	29	31	30	31	30	31	31	30	31	30	31	366
3.	Licensed Beds for Bed Hold Testing. . . .	58	58	58	58	58	58	58	58	58	58	58	58	696
4.	Occupancy Test:													
	Row 2 x (Row 3 x 94%)	1,690	1,581	1,690	1,636	1,690	1,636	1,690	1,690	1,636	1,690	1,636	1,690	19,955
5.	Inhouse patient days	1,375	1,219	1,334	1,241	1,198	1,283	1,594	1,360	1,256	982	958	1,284	15,084
6.	Bed Hold days	-	-	-	-	-	-	-	-	-	-	-	-	-
7.	**TOTAL DAYS . . .**	1,375	1,219	1,334	1,241	1,198	1,283	1,594	1,360	1,256	982	958	1,284	15,084
		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

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SCHEDULE 10: Balance Sheet

ASSETS	Begin Date 1/1/20	End Date 12/31/20
CURRENT ASSETS		
Cash on hand and in bank	$(123,740,887)	$(94,478,936)
Temporary investments		
Resident accounts receivable	30,129,494	26,941,042
Other accounts receivable	5,750,643	3,170,103
Due from related parties	730,018,532	90,632,807
Notes receivable		
Accrued interest receivable		
Inventories	2,034,528	730,218
Prepaid expenses	13,761,080	10,394,796
Resident funds held in trust		
Other current assets, list below:		
TOTAL CURRENT ASSETS	$657,953,390	$37,390,030
PROPERTY, PLANT, EQUIP.		
Land	$21,910,879	$21,351,081
Land improvements		
Buildings	138,281,013	125,754,773
Leasehold improvements		
Fixed equipment		
Moveable equipment	186,703,871	138,387,385
Transportation equipment		
Other	16,641,108	22,138,026
Less: accumulated depreciation	(209,898,930)	(155,527,228)
TOTAL PROPERTY, PLANT, EQUIPMENT	$153,637,941	$152,104,037
OTHER		
Long term investments	$720,730,395	$754,166,151
Other Assets, list below:		
Other Assets	61,246,703	69,465,138
TOTAL OTHER ASSETS	$781,977,098	$823,631,289
TOTAL ASSETS	$1,593,568,429	$1,013,125,356

LIABILITIES AND OWNERS' EQUITY	Begin Date 1/1/20	End Date 12/31/20
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Current Portion Bonds/Notes	$7,119,738	$10,613,104
Due to related parties	1,612,432,064	1,087,678,389
Accounts payable	24,843,891	11,449,471
Accrued salaries	59,066,188	65,246,599
Other accrued expenses	686,966	4,200,081
Resident trust funds payable		
Other current liabilities		10,679,272
TOTAL CURRENT LIABILITIES	$1,704,148,847	$1,189,866,916
LONG TERM LIAB.		
Notes and loans payable (list) below:		
Note Payable	3,681,800	
Bonds Payable	322,562,565	312,722,648
Other long term liabilities	147,184,895	95,213,602
TOTAL LONG TERM LIABILITIES	$473,429,260	$407,936,250
OWNER EQUITY		
OWNERS' EQUITY, list below:		
Retained Earnings	(584,009,678)	(584,677,810)
TOTAL OWNER'S EQUITY	$(584,009,678)	$(584,677,810)
TOTAL LIABILITIES AND EQUITY	$1,593,568,429	$1,013,125,356

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SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)			$(584,009,678)
2.	Add	Net income (from schedule 11, line 19)	$-	
		Owners' capital contribution		
		County appropriation		
		Net decrease in accrued vacation, holiday and sick time		
		Other, Specify: Other Entity Income	3,288,799	
		Other, Specify: Home Office Adjustment	296,725	
		Total additions		3,585,524
3.	Deduct	Net loss (from schedule 11, line 19)	($1,068,317)	
		Dividends and withdrawals	( )	
		Net increase in accrued vacation, holiday and sick time	( )	
		Other, Specify: Other adjustments	(3,185,339)	
		Other, Specify:	( )	
		Total deductions		(4,253,656)
4.	**ENDING OWNERS' EQUITY (schedule 10).**			$(584,677,810)

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	$ 5,554,943
2.	Service fees	schedule 15, line 14A	1,337,462
3.	Rent from outside medical providers	schedule 15, line 14B	-
4.	Other	schedule 15, line 14C	-
5.	Dietary revenues	schedule 16, line 5A	560
6.	Miscellaneous services and materials revenue	schedule 16, line 16	42,292
7.	Rental revenues	schedule 17, line 22	-
8.	Revenues from other major activities	schedule 17, line 38	5,484,853
9.	Sales to related organizations	schedule 18, line 41	-
10.	Investment revenue	schedule 18, line 42	-
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	6,850
14.	Other revenue	schedule 18, line 50	884,936
15.	Subtract: deductions from revenues	schedule 14, line 5	(2,330,530)
16.	NET REVENUES		$ 10,981,366

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 37	$ (11,752,958)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	(296,725)
19.	**NET INCOME OR LOSS**		$ **(1,068,317)**

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SCHEDULE 12: Summary of Total Expenses

All values are automatically posted from other schedules.

Cost Center	Reference	Expense
1. Daily patient service expense	S20, L10	$2,310,059
2. Laboratory & Radiology	S21, L13a	-
3. Respiratory	S21, L13b	-
4. Pharmacy	S21, L13c	20,683
5. PT, OT and Speech	S22, L13a	587,495
6. Dental	S22, L13b	-
7. Physician	S22, L13c	-
8. Social Services	S23, L13a	108,412
9. Recreational Activities	S23, L13b	80,609
10. Religious Services	S23, L13c	-
11. Volunteer Coordinator	S24, L13a	-
12. Ward Clerks	S24, L13b	-
13. Psychotherapy	S24, L13c	-
14. Other	S24, L13d	
15. Dietary	S25, L14a	874,470
16. Plant Operations and Maintenance	S25, L14b	327,043
17. Housekeeping	S25, L14c	176,191
18. Laundry and Linen	S25, L14d	-
19. Security	S25, L14e	-

Cost Center	Reference	Expense
20. Transportation	S25, L14f	$-
21. Administrative service expense	S26, L12	907,459
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L16a	
23. Beauty/Barber Shop	S27, L16b	52,645
24. Hospice	S27, L16c	1,228
25. Heritage (IL/CBRF)	S27, L16d	4,593,829
26. 0	S27, L16e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	1,163,483
28. Heating fuel and utility expense	S29, L10	144,925
29. Interest on operating working capital loans	S30, L6	-
30. Insurance expense	S31, L9	22,605
31. Amortization expense	S32, L5	-
32. Interest on plant asset loans	S33, L15h	-
33. Depreciation expense	S34, L20c	371,072
34. Expense on operating and non-cap.leases	S35, L14	10,750
35. Expense on capitalized leases	S36A, L5	-
36. Property tax expense	S37, L7	-
37. TOTAL EXPENSES FOR REPORT PERIOD		$11,752,958

(To schedule 11, line 17)

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SCHEDULE 13: Summary of Salary & Wage Expenses

All values are automatically posted from other schedules.

Cost Center and Schedule		Total Salary and Wage Expense
Daily patient service	S20, L1d	$1,805,434
Laboratory & Radiology	S21, L1a	-
Respiratory	S21, L1b & 3b	-
Pharmacy	S21, L1c & 3c	-
PT, OT and Speech	S22, L1a &3a	583,441
Dental	S22, L1b &3b	-
Physician	S22, L1c &3c	-
Social Services	S23, L3a	108,412
Recreational Activities	S23, L3b	76,677
Religious Services	S23, L3c	-
Volunteer Coordinator	S24, L3a	-
Ward Clerks	S24, L3b	-
Psychotherapy	S24, L1c & 3c	-
Other	S24, L1d & 3d	-

Cost Center and Schedule			Total Salary and Wage Expense
Dietary		S25, L1a	627,084
Plant operation / maintenance		S25, L1b	61,180
Housekeeping		S25, L1c	100,071
Laundry and Linen		S25, L1d	-
Security		S25, L1e	-
Transportation		S25, L1f	-
Administrative service		S26, L5	489,205
Nurse aide training		S27, L1a	-
Beauty and barber		S27, L1b	49,653
Other, Specify:	Hospice	S27, L1c	607
	Heritage (IL/CBRF)	S27, L1d	2,030,087
	0	S27, L1e	-
TOTAL SALARY AND WAGE EXPENSE			$5,931,851

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SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$2,175,325
2. Medicaid Daily Rate (including bed hold)	2,543,886
3. Private Pay	256,818
4. Medical Supplies,Other	578,914
SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(2,330,530)
SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$3,224,413

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

- [ ] Yes, all significant retroactive Medicaid rate adjustments are included.
- [x] 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 $392.50
8. Facility Comment (Optional)

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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	$13,234			
2. Radiology	7,240			
3. Pharmacy	227,485			
4. Physical therapy	471,566			
5. Speech/hearing therapy	168,059			
6. Occupational therapy	446,080			
7. Physician care				
8. Psychotherapy				
9. Respiratory therapy				
10. Social services				
11. Recreational activities				
12. Special duty nursing				
13. Other, Specify: Central Supply	3,798			
14. TOTAL SPECIAL SERVICE REVENUE	$1,337,462	$-	$-	

SECTION B - THERAPY REVENUES

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY? [X] Yes [ ] No

16. Total gross billings for physical, occupational, and speech therapy services provided at your facility during the cost report period: $1,085,705
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): $1,085,705

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	[X] No	If yes, amount of revenue	
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?	[X] Yes	[ ] No	If yes, amount of revenue	$66,397
21. Did you charge rent to a rehabilitation agency or independent contractor?	[ ] Yes	[X] No	If yes, amount of revenue	

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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)			
4.	Meals On Wheels			
5.	Other Meals Sold	560		
5a.	**TOTAL DIETARY REVENUE**	**$560**		

SECTION B - MISCELLANEOUS SERVICES AND MATERIALS

			Expenses Directly Ascribable To Or Identifiable With Revenue			
		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	42,292	52,645	Barber/Beauty Shop	27	16
10.	Gift Shop					
11.	Canteen and snack counter					
12.	Vending machines					
13.	Sale of clothing					
14.	Television and cable service					
15.	Telephone and Internet					
16.	**TOTAL MISCELLANEOUS SERVICES AND MATERIALS**	**$42,292**				

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SCHEDULE 17: Other Revenues

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

SECTION B - REVENUE FROM MAJOR ACTIVITIES	Revenue	Total Billable Patient Days if revenue generated from activities
23. Another Medicaid nursing home provider		
24. Hospital		
25. Non-Medicaid Nursing Home		
26. Non-Medicaid CBRF	2,272,652	14694
27. Apartment Units	2,829,857	29979
28. Room and Board - Other		
29. Adult Day Care		
30. Home Health		
31. Child Care		
32. Clinic		
33.		
34. Hospice care	382,344	
35.		
36.		
37.		
38. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES	**$5,484,853**	

SCHEDULE 18: Other Revenues

		Revenue
	SALES TO RELATED ORGANIZATIONS	
38.		
39.		
40.		
41.	TOTAL SALES TO RELATED ORGANIZATIONS	$-
42.	TOTAL INVESTMENT REVENUE	
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS	
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES	
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS	$6,850
	OTHER REVENUES	
46.	Other Revenues	$884,936
47.		
48.		
49.		
50.	TOTAL OTHER REVENUES	$884,936

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SCHEDULE 20: Daily Patient Service Expense

Salaries, Wages & Purchased Serv.	A. Registered Nurses	B. Licensed Practical Nurses	C. Nurse Aides and Assistants	D. Total Expenss or Hours
1. TOTAL SALARY AND WAGE EXPENSE	$857,652	$196,042	$751,740	$1,805,434
2. TOTAL SALARY AND WAGE HOURS	22,728 hrs.	7,946 hrs.	45,285 hrs.	$75,959
3. EXPENSE FOR PURCHASED SERVICES	$65,717	$36,335	$57,324	$159,376
AVERAGE WAGE PER HOUR	$37.74	$24.67	$16.60	$23.77
NURSING AND INCONTINENCY SUPPLIES				
4. Catheters, Incontinency Supplies (including purchased laundry service)				
OXYGEN				
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental				
OTHER				
6. Other medical supplies, personal comfort supplies and minor medical equipment				87,190
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				
8. Others				258,059
9.				
10. TOTAL DAILY PATIENT SERVICE EXPENSE				**$2,310,059**

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SCHEDULE 21: Special Service Expenses

		TYPE OF SERVICE		
SECTION A - SALARY AND WAGES		**A. Laboratory & Radiology**	**B. Respiratory**	**C. Pharmacy**
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	$-	$-	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable			
7.	Expense for purchased service - Non billable	$-		
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Pharmacy - legend drugs Billable	$-	$-	20,683
9.	Pharmacy - over the counter drugs Billable	$-	$-	
10.	Supply and Other			
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES**	**$-**	**$-**	**$20,683**
14.	**TOTAL HOURS**	**hrs.**	**hrs.**	**hrs.**

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SCHEDULE 22: Special Service Expenses

		TYPE OF SERVICE		
SECTION A - SALARY AND WAGES		**A. Physical, Occupational And Speech Therapy**	**B. Dental**	**C. Physician**
1.	Expense for hours worked - Billable.	$583,441		
2.	Number of hours worked - Billable.	17,002 hrs.		
3.	Expense for hours worked - Non-billable.			
4.	Number of hours worked - Non-billable.			
5.	TOTAL SALARY AND WAGE EXPENSE	$583,441	$-	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$485		
7.	Expense for purchased service - Non billable			
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies	3,569		
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	TOTAL EXPENSES	$587,495	$-	$-
14.	TOTAL HOURS	17,002 hrs.	hrs.	hrs.

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SCHEDULE 23: Special Service Expenses

		TYPE OF SERVICE		
SECTION A - SALARY AND WAGES		**A. Social Services**	**B. Recreational Activities**	**C. Religious Services**
1.	Expense for hours worked - Billable	$-	$-	$-
2.	Number of hours worked - Billable	hrs.	hrs.	hrs.
3.	Expense for hours worked - Non-billable	$108,412	$76,677	
4.	Number of hours worked - Non-billable	5,096 hrs.	6,072 hrs.	
5.	TOTAL SALARY AND WAGE EXPENSE	$108,412	$76,677	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$-	$-	$-
7.	Expense for purchased service - Non billable		$787	
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies		$3,145	
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES**	**$108,412**	**$80,609**	**$-**
14.	**TOTAL HOURS**	**5,096 hrs.**	**6,072 hrs.**	**hrs.**

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SCHEDULE 24: Special Service Expenses

		TYPE OF SERVICE			
SECTION A - SALARY AND WAGES		**A. Volunteer Coord.**	**B. Ward Clerks**	**C. Psychotherapy**	
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	$-	$-	$-	$-
SECTION B - PURCHASED SERVICES					
6.	Expense for purchased service - Billable				
7.	Expense for purchased service - Non billable				
SECTION C - SUPPLY AND OTHER EXPENSE					
8.					
9.					
10.					
11.					
12.					
SECTION D - TOTAL					
13.	**TOTAL EXPENSES**	$-	$-	$-	
14.	**TOTAL HOURS**	hrs.	hrs.	hrs.	hrs.

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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	$627,084	$61,180	$100,071			
2. NUMBER OF HOURS WORKED	53,026 hrs.	4,865 hrs.	8,254 hrs.			
SECTION B - DIETICIAN CONSULTANT						
3. Dietician consultant expense		$-	$-	$-	$-	$-
SECTION C - OUTSIDE SERVICE						
4. Purchased Services	$5,854	$73,950	$54,882			
5.						
6.						
7.						
8. **TOTAL OUTSIDE SERVICE EXPENSES**	$5,854	$73,950	$54,882	$-	$-	$-
SECTION D - SUPPLY AND OTHER EXPENSE						
9. Supplies	$15,463	$28,736	$21,238			
10. Food	226,069					
11. Repairs & Maintenance		163,177				
12.						
13.						
SECTION E - TOTAL						
14. **TOTAL EXPENSES**	**$874,470**	**$327,043**	**$176,191**	**$-**	**$-**	**$-**

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SCHEDULE 25A: Support Services Expense Allocations

SECTION A - ALLOCATION OF DIETARY EXPENSES

1.	Total dietary expenses (from Schedule 25, Line 14a)	$874,470
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)	$874,470

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other
6.	Meals served	45,252	45,252				
7.	Ratio to total meals served to 4 decimals	1.0000	1.0000				
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$874,470 From line 5	$874,470 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 Area	B. Nursing Home Area	C. Emp. Unique Fringe Benefit Area	Non-Nursing Home Areas w/ Plant Operation and Maint. D. Hospice	E.	F.
12.	Total square feet for areas	46,925	42,307		4,618		
13.	Ratio to total square feet to 4 decimals . .	1.0000	0.9016		0.0984		
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$327,043 From S25, L18	$294,862 14A x 13B	$- 14A x 13C	$32,181 14A x 13D	$- 14A x 13E	$- 14A x 13F

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SCHEDULE 25B: Support Services Expense Allocations

SECTION A - ALLOCATION OF HOUSEKEEPING EXPENSES

		A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Housekeeping Services: Hospice		
15.	Square feet or hours of service provided	46,925	42,307	4,618		
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	0.9016	0.0984		
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$176,191	$158,854	$17,337	$-	$-
		From S25, L18	17A x 16B	17A x 16C	17A x 16D	17A x 16E

SECTION B - ALLOCATION OF LAUNDRY AND LINEN EXPENSES

		A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Laundry/Linen Services		
18.	Pounds of laundry processed	-				
19.	Ratio to total pounds to 4 decimals	1.0000				
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.		$-	$-	$-	$-
		From S25, L18	20A x 19B	20A x 19C	20A x 19D	20A x 19E

SECTION C - ALLOCATION OF SECURITY EXPENSES

		A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Security Services		
21.	Total square feet of area	-				
22.	Ratio to total square feet to 4 decimals . .	1.0000				
23.	TOTAL SECURITY EXPENSE ALLOC.		$-	$-	$-	$-
		From S25, L18	23A x 22B	23A x 22C	23A x 22D	23A x 22E

SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES

		A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Transportation Services		
24.	Alloc. Basis, Specify:	-				
25.	Ratio to total alloc. basis to 4 decimals	1.0000				
26.	TOTAL TRANS. EXPENSE ALLOC.		$-	$-	$-	$-
		From S25, L18	26A x 25B	26A x 25C	26A x 25D	26A x 25E

SCHEDULE 26: Administrative Service Expenses

		Expenses
SECTION A - SALARY AND WAGES		
1.	General Admin & Accounting	$476,832
2.	Medical Records	12,373
3.	Central Supply	
4.	Scheduling	
5.	Total Salary and Wage Expense	$489,205
SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS		
6.	Home office costs allocated to facility	
	Name of home office: ThedaCare	
	From (date): 1/1/2020	
	Through (date): 12/31/2020	
7.	County costs allocated to facility	
SECTION C - NON-SALARY EXPENSES		
8.	Purchased services - legal	
9.	Licensed bed assessment	118,320
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	299,934
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	$907,459

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Purchased Services	$39,353
2.	Admin Supplies	7,482
3.	Telephone	4,045
4.	Conferences & Travel	3,379
5.	Training & Education	860
6.	Dues	19,345
7.	Professional Services Fees	70,878
8.	Information Technology	9,306
9.	Other	230
10.	Personal Property Taxes (Non-Allowable)	28,000
11.	Other Contracted Labor	117,056
12.		
13.		
14.		
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .**	**$299,934**

SCHEDULE 26: Related Party Administrative Service Expenses

		Expenses
SECTION A - SALARY AND WAGES		
1.	General Admin & Accounting	
2.	Medical Records	
3.	Central Supply	
4.	Scheduling	
5.	Total Salary and Wage Expense	$-
SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS		
6.	Home office costs allocated to facility	
	Name of home office	
	From (date)	
	Through (date)	
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	$-

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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. TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11).	**$-**

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SCHEDULE 26B: Allocation of Administrative Expenses

1. Total Admin. Service Expense (S26, 12) $907,459

SECTION A - DIRECT EXPENSES

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	Non-Nursing Home Areas Receiving Administrative Services		
2. N/A	$-	$-			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.	$-	$-			
16. NET UNASSIGNED EXPENSE	$907,459				

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	$907,459	907,459	-	-	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE	$907,459	$907,459	$-	$-	$-
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

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SCHEDULE 27: Other Cost Centers

SECTION A - SALARY AND WAGES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**Hospice**	**Heritage (IL/CBRF)**	
1. TOTAL SALARY AND WAGE EXPENSE		$49,653	$607	$2,030,087	
2. NUMBER OF HOURS WORKED		2,867 hrs.	184 hrs.	173,728 hrs.	

SECTION B - NON-SALARY EXPENSES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**Hospice**	**Heritage (IL/CBRF)**	**-**
3. Supplies & Equipment				$691,023	
4. Purchased Services				255,055	
5. Benefits				533,634	
6. Depreciation				765,747	
7. Insurance				16,155	
8. Utilities				302,128	
9. Other		2,992	621		
10.					
11.					
12.					
13.					
14.					
15. **TOTAL NON-SALARY EXPENSES**	$-	$2,992	$621	$2,563,742	$-

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**Hospice**	**Heritage (IL/CBRF)**	**-**
16. TOTAL EXPENSES		**$52,645**	**$1,228**	**$4,593,829**	

SCHEDULE 28: Fringe Benefits

	Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1.	Employer's share of F.I.C.A.		$294,896
2.	State unemployment compensation		
3.	Federal unemployemnt compensation		
4.	Worker's compensation insurance	☐ Yes ☐ No	
5.	Health, Dental & Vision Insurance	☒ Yes ☐ No	485,397
6.	Life and disability insurance	☐ Yes ☐ No	
7.	Wage continuation insurance	☐ Yes ☐ No	
8.	Pension and deferred comp. plans (section C)	☐ Yes ☐ No	
9.	Post-Employment Physicals and Vaccines		
10.	Uniforms		
11.	Misc Employee Benefits		383,190
12.			
13.			
14.			
15.	TOTAL PAID ON BEHALF OF EMPLOYEES		$1,163,483
16.	Expense for special salary or wage payments to employees not included elsewhere		

- ☐ Christmas bonus
- ☐ Longevity bonus
- ☐ Productivity bonus
- ☐ Bonuses to owners and immediate family relations, Specify:
- ☐ Other, Specify:

17.	**TOTAL FRINGE BENEFIT EXPENSE**	**$1,163,483**

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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?		x			
1	Actual Claims Paid		$737,639			
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		252,242			
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)	$-	$485,397	$-	$-	$-

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SCHEDULE 29: Heating and Utility Service Expenses

SECTION A - ACCRUED EXPENSE BY TYPE

		Accrued Expense			Accrued Expense
1.	Fuel oil		6.	Water and sewer utility charges	10,342
2.	Natural gas		7.	Purchased steam	
3.	L.P. gas		8.	Telephone	-
4.	Coal		9.	Others	72,061
5.	Electricity	62,522	**10.**	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$144,925**

SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE

					Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.		
		A. Total	**B. NH Area**	**C. Emp. Unique Fringe Ben. Area**	**Hospice**		
11.	Total square feet for areas	46,925	42,307		4,618		
12.	Ratio to total square feet to 4 decimals	1.0000	0.9016		0.0984		
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**144,925**	**$130,664**	**$-**	**$14,261**	**$-**	**$-**
		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.		☐ Yes ☐ No	
2.		☐ Yes ☐ No	
3.		☐ Yes ☐ No	
4.		☐ Yes ☐ No	
5.		☐ Yes ☐ No	
6.	**TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS**		**$-**

SCHEDULE 31: Accrued Insurance Expenses

	A. Type of Insurance Coverage	B. Self-Funded?	C. Insurance Expense
1.	Property insurance on building and contents	☐ Yes ☐ No	
2.	Automobile insurance	☐ Yes ☐ No	
3.	Liability insurance	☐ Yes ☒ No	22,605
4.	Business interruption insurance	☐ Yes ☐ No	
5.	Life insurance on owners and employes with facility as the beneficiary	☐ Yes ☐ No	
6.	Mortgage insurance	☐ Yes ☐ No	
7.	Other Property	☐ Yes ☐ No	
8.	Other General	☐ Yes ☐ No	
9.	**TOTAL INSURANCE EXPENSE.**		**$22,605**

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.	**TOTAL AMORTIZATION EXPENSE**						**$-**

SCHEDULE 30RP: Related Party Working Capital Loans

	A. Name of Lender	B. Is Lender a Related Party?	C. Interest Expense
1.		☐ Yes ☐ No	
2.		☐ Yes ☐ No	
3.		☐ Yes ☐ No	
4.		☐ Yes ☐ No	
5.		☐ Yes ☐ No	
6.	**TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS**		$-

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	☐ Yes ☐ No	
2.	Automobile insurance	☐ Yes ☐ No	
3.	Liability insurance	☐ Yes ☐ No	
4.	Business interruption insurance	☐ Yes ☐ No	
5.	Life insurance on owners and employes with facility as the beneficiary	☐ Yes ☐ No	
6.	Mortgage insurance	☐ Yes ☐ No	
7.		☐ Yes ☐ No	
8.		☐ Yes ☐ No	
9.	**TOTAL INSURANCE EXPENSE**		$-

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.	**TOTAL AMORTIZATION EXPENSE**						$-

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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 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.	G. Interest Rate	H. Interest Expense
1. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
2. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
3. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
4. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
5. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
6. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
7. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2)				$-	$-	$-		$-

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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 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.	G. Interest Rate	H. Interest Expense
8. Name Related party? ☐ Yes ☐ No Purpose								
9. Name Related party? ☐ Yes ☐ No Purpose								
10. Name Related party? ☐ Yes ☐ No Purpose								
11. Name Related party? ☐ Yes ☐ No Purpose								
12. Name Related party? ☐ Yes ☐ No Purpose								
13. Name Related party? ☐ Yes ☐ No Purpose								
14. Name Related party? ☐ Yes ☐ No Purpose								

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

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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 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.	G. Interest Rate	H. Interest Expense
1. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
2. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
3. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
4. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
5. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
6. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
7. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).				$-	$-	$-		$-

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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 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.	G. Interest Rate	H. Interest Expense
8. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
9. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
10. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
11. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
12. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
13. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
14. Name _____ Related party? ☐ Yes ☐ No Purpose _____								

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

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SCHEDULE 34: Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date 1/1/2020 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date 12/31/2020 E. Ending Balance
1. Land	426,723		( )	$426,723
2. Land Improvements	684,694		( )	684,694
3. Buildings	27,433,197	34,140	( )	27,467,337
4. Leasehold Improvements	-		( )	-
5. Fixed equipment	-		( )	-
6. Moveable equipment	5,499,084	96,220	( )	5,595,304
7. Transportation vehicles	-		( )	-
8.			( )	-
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$34,043,698	$130,360	($-)	$34,174,058

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date 1/1/2020 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 12/31/2020 E. Ending Balance
11. Land Improvements		$-		( )	$-
12. Buildings		5,365,047	327,765	( )	5,692,812
13. Leasehold Improvements		-		( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment		1,716,798	43,307	( )	1,760,105
16. Transportation vehicles		-		( )	-
17.				( )	-
18.				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$7,081,845		($-)	$7,452,917
20. TOTAL DEPRECIATION EXPENSE			**$371,072**		

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

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 34RP: Related Party Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date 1/1/2020 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date 12/31/2020 E. Ending Balance
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 1/1/2020 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 12/31/2020 E. Ending Balance
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

Medicaid PopID & Provider Number 733-20188400

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.		☐ Yes ☐ No	☐ Yes ☐ No				
2.		☐ Yes ☐ No	☐ Yes ☐ No				
3.		☐ Yes ☐ No	☐ Yes ☐ 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.	Accelerated care Plus Leasing	☐ Yes ☒ No	☐ Yes ☒ No		Jan-20	Rental Equipment	$10,750
5.		☐ Yes ☐ No	☐ Yes ☐ No				
6.		☐ Yes ☐ No	☐ Yes ☐ No				
7.		☐ Yes ☐ No	☐ Yes ☐ No				
8.		☐ Yes ☐ No	☐ Yes ☐ No				
9.		☐ Yes ☐ No	☐ Yes ☐ No				
10.		☐ Yes ☐ No	☐ Yes ☐ No				
11.		☐ Yes ☐ No	☐ Yes ☐ No				
12.		☐ Yes ☐ No	☐ Yes ☐ No				
13.		☐ Yes ☐ No	☐ Yes ☐ No				

SECTION C - TOTAL

14. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES **$10,750**

Medicaid PopID & Provider Number 733-20188400

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 . . . . . **$-**

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SCHEDULE 36B: Capitalized Leases

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor _____ A2. Actual payments required by lease in report period . . . . . _____

A3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No A4. If yes, (schedule) _____(line) _____(amount) _____

B1. Name of lessor _____ B2. Actual payments required by lease in report period . . . . . _____

B3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No B4. If yes, (schedule) _____(line) _____(amount) _____

C1. Name of lessor _____ C2. Actual payments required by lease in report period . . . . . _____

C3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No C4. If yes, (schedule) _____(line) _____(amount) _____

D1. Name of lessor _____ D2. Actual payments required by lease in report period . . . . . _____

D3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☐ No D4. If yes, (schedule) _____(line) _____(amount) _____

E. TOTAL CAPITALIZED LEASE PAYMENTS RELATED TO CAPITALIZED LEASES . . . . . $-

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SCHEDULE 37: 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. _____

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

Medicaid PopID & Provider Number 733-20188400

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 . . . . . **$-**

SCHEDULE 38 - NO LONGER USED

SCHEDULE 39 - NO LONGER USED

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 40: Allocated Property Expenses

			Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities		
			C.	D.	E.
SECTION A - DIRECT PROPERTY EXP.	**A. Total From Sched.**	**B. NH Service Area**	**Hospice**		
1. Property insurance (s31)	$-				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	-				
4. Plant asset interest expense (s33)	-				
5. Depreciation land improvements (s34)	-				
6. Depreciation buildings (s34)	327,765				
7. Depreciation leasehold improve. (s34)	-				
8. Depreciation fixed equipment (s34)	-				
9. Depreciation moveable equip. (s34)	43,307				
10. Depreciation transportation veh. (s34)	-				
11. Depreciation other (s34)	-				
12. Expense on operating leases (s35)	10,750				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	-				
15. TOTAL EXPENSE	$381,822	$-			
16. Less total directly assigned property exp.	$-				
17. NET UNASSIGNED/INDIRECT PROP.	**$381,822**				
SECTION B - NON-SALARY EXPENSES	**A. Total From Sched.**	**B. NH Area**	**Hospice**		
18. Square feet of service's building area	46,925	42,307	4,618		
19. Ratio to total square feet to 4 decimals	1.0000	0.9016	0.0984		
20. Indirect property expense allocation	$381,822 (from 17A)	344,251 20A x 19B	37,571 20A x 19C	- 20A x 19D	- 20A x 19E
SECTION C - TOTAL	**A. Total From Sched.**	**B. NH Area**	**Hospice**		
21. TOTAL PROP. EXP. FOR EACH AREA	**$381,822** 17A + 20 A	**$344,251** 15B + 20B	**$37,571** 15C + 20C	**$-** 15D + 20D	**$-** 15E + 20E

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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. [X] Accrual [ ] Cash

2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.
Items with a cost equal to or greater than $2,000 and a life greater than 12 months.

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?	
1. Vacation	[X] Actual	[ ] Earned	[ ] Yes	[X] No
2. Holidays	[X] Actual	[ ] Earned	[ ] Yes	[X] No
3. Sick time	[X] Actual	[ ] Earned	[ ] Yes	[X] No
4. Break, meal time	[X] Actual	[ ] Earned	[ ] Yes	[X] No
5. Holiday premium	[X] Actual	[ ] Earned	[ ] Yes	[X] No
6. In-service training	[X] Actual	[ ] Earned	[ ] Yes	[X] No
7. _____	[ ] Actual	[ ] Earned	[ ] Yes	[ ] No

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

SECTION A - RELATED PARTY LEASES

	A. Description of Expense Item	B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Net Expense
		Location and Amount of Expense Included in This Cost Report				
1.	Total related party lease expense					
2.	Insurance expense					
3.	Amortization deferred expense					
4.	Interest expense					
5.	Depreciation expense					
6.	Property tax expense					
7.						
8.						
9.	SUBTOTAL FOR RELATED PARTY LEASES					$-

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10.	Home Office Allocation	Admin	26	E	6	$296,725
11.						
12.						
13.						
14.						
15.	**TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)**					$296,725

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.

ThedaCare Inc

Medicaid PopID & Provider Number 733-20188400

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-employes					
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 Abondoned Planning Expenses					
21 Other - describe: _____					
22. Other - describe: _____					

SCHEDULE 43A - NO LONGER USED

SCHEDULE 44 - NO LONGER USED

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

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 46: Identification of Expenses for Employee Unique Fringe Benefits

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

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 49: Percentage of Ownership

	Name of Individual or Entity	Percentage of Ownership
1.	ThedaCare, Inc	100%
2.		
3.		
4.		
5.		

SCHEDULE 50: Interest in Other Providers

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

SCHEDULE 51 - NO LONGER USED

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 52: Miscellaneous Medicaid Non-Rate Revenues

Medicaid Revenue Item	Revenue Amount	Location in Cost Report: Schedule	Location in Cost Report: 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……			
4. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES	**$-**		

Medicaid PopID & Provider Number 733-20188400

SCHEDULE 53: Incentives – Private Room & Property

SECTION A - PRIVATE ROOM INCENTIVE

Indicate if your facility is requesting a private room incentive

[x] Yes, my facility is requesting the private room incentive.

AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2021, to June 30, 2022, the Peabody Manor 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.

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