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	
The Bay at Oconto Health and Rehab. Center	920-834-4575	administrator@bay-oconto.com	
Facility Street Address	**City**	**State**	**Zip Code**
101 First Street	Oconto	WI	54153

Contact Person	Contact Telephone Number	Contact Email Address
Carol Vincent	920-842-1111	c.vincent@championhcare.com

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	100089231	1902460348	766

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Brianna Gretzinger	Ephraim Fink	Champion Care Home Office

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

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

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

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

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

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

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

Medicaid PopID & Provider Number 766-100089231

SCHEDULE 2: Provider Notes

Corporate Office: Champion Care, Rockville Centre, NY

Medicaid PopID & Provider Number 766-100089231

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: Oconto — County Code: 42

4. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, complete Schedule S-F FB. [ ] (1) Yes [X] (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	50
Beds at End of Cost Reporting Period	12/31/2020	50

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 [X] (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.	The Bay at Oconto Health and Rehab. Ce	5009	22	28	50
2.					-
3.					-
4.	TOTAL		22	28	50

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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: PT,OT,ST	☐	☐	☐	x	x	☐	x	x
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	☐	☐	☐	x	x	☐	x	x

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)	9,516		9,516
1b.	ICF-IID Medicaid (T-19)			-
1c.	Family Care (T-19)	801		801
1d.	Other Medicaid Managed Care (T-19)			-
1e.	Hospice (T-19)	483		483
1f.	Ventilator (T-19)			-
2a.	Medicare (T-18)	2,236		2,236
2b.	Medicare Advantage, for days covered as a Part A stay	628		628
3a.	Private pay & Insurance	1,405		1,405
3b.	Medicare Advantage, for days not covered as a Part A stay			-
3c.	Hospice (Private pay & Insurance)			-
4.	Other, Specify:			
5.	TOTAL INHOUSE PATIENT DAYS	15,069	-	15,069

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**	**15,069**	**-**	**15,069**

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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. . . .	50	50	50	50	50	50	50	50	50	50	50	50	600
4.	Occupancy Test:													
	Row 2 x (Row 3 x 94%)	1,457	1,363	1,457	1,410	1,457	1,410	1,457	1,457	1,410	1,457	1,410	1,457	17,202
5.	Inhouse patient days	1,275	1,214	1,356	1,336	1,284	1,222	1,284	1,260	1,241	1,367	1,110	1,120	15,069
6.	Bed Hold days	-	-	-	-	-	-	-	-	-	-	-	-	-
7.	**TOTAL DAYS . . .**	1,275	1,214	1,356	1,336	1,284	1,222	1,284	1,260	1,241	1,367	1,110	1,120	15,069
		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: 0

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	$(21,939)	$514,380
Temporary investments		
Resident accounts receivable	348,201	406,811
Other accounts receivable	8,122	8,122
Due from related parties	243,295	530,354
Notes receivable		
Accrued interest receivable		
Inventories		
Prepaid expenses	50,732	38,808
Resident funds held in trust		
Other current assets, list below:		
Capex Escrow	(20,340)	(41,693)
TOTAL CURRENT ASSETS	$608,071	$1,456,782
PROPERTY, PLANT, EQUIP.		
Land		
Land improvements		
Buildings		
Leasehold improvements	21,353	32,119
Fixed equipment		
Moveable equipment	4,678	11,703
Transportation equipment		
Other	1,400	11,740
Less: accumulated depreciation	(587)	(7,407)
TOTAL PROPERTY, PLANT, EQUIPMENT	$26,844	$48,155
OTHER		
Long term investments		
Other Assets, list below:		
TOTAL OTHER ASSETS	$-	$-
TOTAL ASSETS	$634,915	$1,504,937

LIABILITIES AND OWNERS' EQUITY	Begin Date 1/1/20	End Date 12/31/20
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Credit Card Payable	$15,790	$(16,817)
Due to related parties		
Accounts payable	202,452	222,295
Accrued salaries	37,753	61,279
Other accrued expenses	4,686	6,119
Resident trust funds payable		
Other current liabilities	56,207	39,246
TOTAL CURRENT LIABILITIES	$316,888	$312,122
LONG TERM LIAB.		
Notes and loans payable (list) below:		
Note Payable	133,333	(114,957)
Loan Payable - Stimulus	-	318,239
Other long term liabilities		
TOTAL LONG TERM LIABILITIES	$133,333	$203,282
OWNER EQUITY		
OWNERS' EQUITY, list below:		
Distributions	-	250,050
Net Income (Loss)	184,694	1,054,889
Retained Earnings	-	(315,406)
TOTAL OWNER'S EQUITY	$184,694	$989,533
TOTAL LIABILITIES AND EQUITY	$634,915	$1,504,937

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SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)			$184,694
2.	Add: Net income (from schedule 11, line 19)		$700,104	
	Owners' capital contribution			
	County appropriation			
	Net decrease in accrued vacation, holiday and sick time			
	Other, Specify:	Related Party Expenses	354,785	
	Other, Specify:			
	Total additions			1,054,889
3.	Deduct: Net loss (from schedule 11, line 19)		($-)	
	Dividends and withdrawals		( )	
	Net increase in accrued vacation, holiday and sick time		( )	
	Other, Specify:	Equity Adjustment	(250,050)	
	Other, Specify:		( )	
	Total deductions			(250,050)
4.	**ENDING OWNERS' EQUITY (schedule 10).**			$989,533

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	$ 2,859,976
2.	Service fees	schedule 15, line 14A	1,335,626
3.	Rent from outside medical providers	schedule 15, line 14B	-
4.	Other	schedule 15, line 14C	-
5.	Dietary revenues	schedule 16, line 5A	-
6.	Miscellaneous services and materials revenue	schedule 16, line 16	3,260
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	-
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	181,335
15.	Subtract: deductions from revenues	schedule 14, line 5	(43,997)
16.	NET REVENUES		$ 4,336,200

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 37	$ (3,281,311)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	(354,785)
19.	**NET INCOME OR LOSS**		$ **700,104**

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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	$1,043,131
2. Laboratory & Radiology	S21, L13a	4,426
3. Respiratory	S21, L13b	-
4. Pharmacy	S21, L13c	71,355
5. PT, OT and Speech	S22, L13a	254,501
6. Dental	S22, L13b	-
7. Physician	S22, L13c	8,700
8. Social Services	S23, L13a	32,813
9. Recreational Activities	S23, L13b	46,945
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	270,897
16. Plant Operations and Maintenance	S25, L14b	63,173
17. Housekeeping	S25, L14c	48,706
18. Laundry and Linen	S25, L14d	32,434
19. Security	S25, L14e	843

Cost Center	Reference	Expense
20. Transportation	S25, L14f	$6,833
21. Administrative service expense	S26, L12	698,467
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L16a	135
23. Beauty/Barber Shop	S27, L16b	3,236
24.	S27, L16c	
25.	S27, L16d	
26.	S27, L16e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	300,898
28. Heating fuel and utility expense	S29, L10	65,111
29. Interest on operating working capital loans	S30, L6	13,072
30. Insurance expense	S31, L9	34,872
31. Amortization expense	S32, L5	-
32. Interest on plant asset loans	S33, L15h	-
33. Depreciation expense	S34, L20c	6,820
34. Expense on operating and non-cap.leases	S35, L14	241,403
35. Expense on capitalized leases	S36A, L5	-
36. Property tax expense	S37, L7	32,540
37. TOTAL EXPENSES FOR REPORT PERIOD		$3,281,311

(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	Cost Center and Schedule		Total Salary and Wage Expense
Daily patient service	S20, L1d	$966,427	Dietary	S25, L1a	166,618
Laboratory & Radiology	S21, L1a	-	Plant operation / maintenance	S25, L1b	35,553
Respiratory	S21, L1b & 3b	-	Housekeeping	S25, L1c	40,831
Pharmacy	S21, L1c & 3c	-	Laundry and Linen	S25, L1d	30,353
PT, OT and Speech	S22, L1a &3a	218,832	Security	S25, L1e	-
Dental	S22, L1b &3b	-	Transportation	S25, L1f	5,155
Physician	S22, L1c &3c	-	Administrative service	S26, L5	187,899
Social Services	S23, L3a	32,771	Nurse aide training	S27, L1a	-
Recreational Activities	S23, L3b	44,129	Beauty and barber	S27, L1b	2,866
Religious Services	S23, L3c	-	Other, Specify:	S27, L1c	-
Volunteer Coordinator	S24, L3a	-		S27, L1d	-
Ward Clerks	S24, L3b	-		S27, L1e	-
Psychotherapy	S24, L1c & 3c	-	**TOTAL SALARY AND WAGE EXPENSE**		$1,731,434
Other	S24, L1d & 3d	-			

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SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$466,720
2. Medicaid Daily Rate (including bed hold)	1,608,407
3. Private Pay	323,820
4. Medical Supplies,Other	461,029
SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(43,997)
SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$2,815,979

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

- [X] 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 $240.00
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				
2.	Radiology	36,006			
3.	Pharmacy	21,132			
4.	Physical therapy	574,770			
5.	Speech/hearing therapy	164,600			
6.	Occupational therapy	537,685			
7.	Physician care				
8.	Psychotherapy				
9.	Respiratory therapy				
10.	Social services				
11.	Recreational activities				
12.	Special duty nursing				
13.	Other, Specify: Ambulance	1,433			
14.	TOTAL SPECIAL SERVICE REVENUE	$1,335,626	$-	$-	

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: $1,277,055
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): $1,277,055

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	$414,645
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			
5a.	**TOTAL DIETARY REVENUE**	**$-**		

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	3,184				
10.	Gift Shop					
11.	Canteen and snack counter					
12.	Vending machines	76				
13.	Sale of clothing					
14.	Television and cable service					
15.	Telephone and Internet					
16.	**TOTAL MISCELLANEOUS SERVICES AND MATERIALS**	**$3,260**				

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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		
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.		
38. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES	$-	

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	
	OTHER REVENUES	
46.	PASSAR Billing	$1,650
47.	Other Income	20,182
48.	COVID Revenue	159,503
49.		
50.	TOTAL OTHER REVENUES	$181,335

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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	$369,089	$175,478	$421,860	$966,427
2. TOTAL SALARY AND WAGE HOURS	10,621 hrs.	7,838 hrs.	24,243 hrs.	$42,702
3. EXPENSE FOR PURCHASED SERVICES				$-
AVERAGE WAGE PER HOUR	$34.75	$22.39	$17.40	$22.63
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				2,074
OTHER				
6. Other medical supplies, personal comfort supplies and minor medical equipment				71,235
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				3,395
8.				
9.				
10. TOTAL DAILY PATIENT SERVICE EXPENSE				**$1,043,131**

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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	$-		$11,991
SECTION C - SUPPLY AND OTHER EXPENSE			
8. Pharmacy - legend drugs Billable	$-	$-	59,364
9. Pharmacy - over the counter drugs Billable	$-	$-	
10. Supply and Other			
11. Supplies	4,426		
12.			
SECTION D - TOTAL			
13. TOTAL EXPENSES	**$4,426**	**$-**	**$71,355**
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.	$218,832		
2.	Number of hours worked - Billable.	7,202 hrs.		
3.	Expense for hours worked - Non-billable.			
4.	Number of hours worked - Non-billable.			
5.	TOTAL SALARY AND WAGE EXPENSE	$218,832	$-	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable			
7.	Expense for purchased service - Non billable			$8,700
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies	35,669		
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	TOTAL EXPENSES	$254,501	$-	$8,700
14.	TOTAL HOURS	7,202 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	$32,771	$44,129	
4.	Number of hours worked - Non-billable	1,938 hrs.	4,214 hrs.	
5.	TOTAL SALARY AND WAGE EXPENSE	$32,771	$44,129	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$-	$-	$-
7.	Expense for purchased service - Non billable			
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies	$42	$2,816	
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES . . . . . .**	**$32,813**	**$46,945**	**$-**
14.	**TOTAL HOURS . . . . . .**	**1,938 hrs.**	**4,214 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	$166,618	$35,553	$40,831	$30,353		$5,155
2. NUMBER OF HOURS WORKED	13,950 hrs.	2,085 hrs.	4,495 hrs.	2,069 hrs.		388 hrs.
SECTION B - DIETICIAN CONSULTANT						
3. Dietician consultant expense	$857	$-	$-	$-	$-	$-
SECTION C - OUTSIDE SERVICE						
4. Contracted Services		$22,999				
5.						
6.						
7.						
8. **TOTAL OUTSIDE SERVICE EXPENSES**	$-	$22,999	$-	$-	$-	$-
SECTION D - SUPPLY AND OTHER EXPENSE						
9. Supplies	$22,576	$4,621	$7,875	$2,081	$843	$1,678
10. Food	80,846					
11.						
12.						
13.						
SECTION E - TOTAL						
14. TOTAL EXPENSES	**$270,897**	**$63,173**	**$48,706**	**$32,434**	**$843**	**$6,833**

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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)	$270,897
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)	$270,897

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other
6.	Meals served	45,207	45,207				
7.	Ratio to total meals served to 4 decimals	1.0000	1.0000				
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$270,897 From line 5	$270,897 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.	E.	F.
12.	Total square feet for areas	33,725	33,725				
13.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000				
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$63,173 From S25, L18	$63,173 14A x 13B	$- 14A x 13C	$- 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		
15.	Square feet or hours of service provided	33,725	33,725			
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$48,706	$48,706	$-	$-	$-
		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	60,276	60,276			
19.	Ratio to total pounds to 4 decimals	1.0000	1.0000			
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.	$32,434	$32,434	$-	$-	$-
		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	33,725	33,725			
22.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000			
23.	TOTAL SECURITY EXPENSE ALLOC.	$843	$843	$-	$-	$-
		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: Revenue	2,815,979	2,815,979			
25.	Ratio to total alloc. basis to 4 decimals	1.0000	1.0000			
26.	TOTAL TRANS. EXPENSE ALLOC.	$6,833	$6,833	$-	$-	$-
		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	$153,951
2.	Medical Records	
3.	Central Supply	33,948
4.	Scheduling	
5.	Total Salary and Wage Expense	$187,899
SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS		
6.	Home office costs allocated to facility	
	Name of home office: Champion Care LLC	
	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	$560
9.	Licensed bed assessment	105,734
10.	Contractual management fees	218,378
11.	Total other non-salary (from schedule 26 attachment)	185,896
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	$698,467

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Employee Background Checks & Placement & Recruitment & Retention	$4,770
2.	Office Supplies and Equipment and Office Training Costs	6,398
3.	Accounting Fee & FISC Svc PS & Payroll Fees	29,364
4.	IT Support and Software and Software Rental	31,851
5.	Consultant	55,397
6.	Bank Charges & Late Fees & Bad Debt	5,371
7.	TV & Internet & Telephone	14,093
8.	Mail Postage & Printing & Duplicating	1,028
9.	Licenses, Permits & Fees & Subscriptions	5,754
10.	Charitable Donations	222
11.	Advertising & Marketing	8,691
12.	Auto Expense & Travel & Entertainment	18,877
13.	Non-Eligible RE and PP Taxes	(1,039)
14.	Non-Eligible Leases	5,119
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .**	**$185,896**

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) $698,467

SECTION A - DIRECT EXPENSES

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	Non-Nursing Home Areas Receiving Administrative Services		
2. Administrative Expenses	$(698,467)	$698,467			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.	$(698,467)	$698,467			
16. NET UNASSIGNED EXPENSE	$-				

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	$698,467	$698,467	$-	$-	$-
	(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**			
1. TOTAL SALARY AND WAGE EXPENSE		$2,866			
2. NUMBER OF HOURS WORKED		223 hrs.			

SECTION B - NON-SALARY EXPENSES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**			
3. Nurse Aide Training	$135				
4. Supplies		370			
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15. **TOTAL NON-SALARY EXPENSES**	$135	$370	$-	$-	$-

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**			
16. TOTAL EXPENSES	**$135**	**$3,236**			

SCHEDULE 28: Fringe Benefits

	Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1.	Employer's share of F.I.C.A.		$155,625
2.	State unemployment compensation		
3.	Federal unemployemnt compensation		
4.	Worker's compensation insurance	☐ Yes ☒ No	31,704
5.	Health, Dental & Vision Insurance	☐ Yes ☒ No	108,147
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		488
10.	Uniforms		
11.	Employee Benefits		4,934
12.			
13.			
14.			
15.	TOTAL PAID ON BEHALF OF EMPLOYEES		$300,898
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**	**$300,898**

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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?					
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)	$-	$-	$-	$-	$-

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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	11,683
2.	Natural gas	17,209	7.	Purchased steam	
3.	L.P. gas		8.		
4.	Coal		9.		
5.	Electricity	36,219	**10.**	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$65,111**

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**			
11.	Total square feet for areas	33,725	33,725				
12.	Ratio to total square feet to 4 decimals	1.0000	1.0000				
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**65,111**	**$65,111**	**$-**	**$-**	**$-**	**$-**
		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.	Metropolitan Bank	[ ] Yes [X] No	$13,072
2.		[ ] Yes [ ] No	
3.		[ ] Yes [ ] No	
4.		[ ] Yes [ ] No	
5.		[ ] Yes [ ] No	
6.	**TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS**		**$13,072**

SCHEDULE 31: Accrued Insurance Expenses

	A. Type of Insurance Coverage		B. Self-Funded?	C. Insurance Expense
1.	Property insurance on building and contents		[ ] Yes [X] No	$10,187
2.	Automobile insurance		[ ] Yes [X] No	3,433
3.	Liability insurance		[ ] Yes [X] No	16,987
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	EPLI & Flood & Bond Insurance	[ ] Yes [X] No	4,265
9.	**TOTAL INSURANCE EXPENSE**			**$34,872**

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**						**$-**

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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: Metropolitan Commercial Ba Related party? [ ] Yes [X] No Purpose: Purchase Nursing Facilitiy - Interest Rate is variable - Column G Line 1b is average interest rate for 2019.	May-19	May-22	$1,143,558	$1,143,558	$1,141,952	$-	5.50%	$42,606
2. Name: Metropolitan Commercial Related party? [ ] Yes [X] No Purpose: Refinance Nursing Facility Purchase	Sep-20	May-22	$4,000,000	$4,000,000	$-	$3,982,456	505.00%	$56,147
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).				$5,143,558	$1,141,952	$3,982,456		$98,753

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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	-		( )	$-
2.	Land Improvements	-		( )	-
3.	Buildings	-		( )	-
4.	Leasehold Improvements	21,353	10,766	( )	32,119
5.	Fixed equipment	-		( )	-
6.	Moveable equipment	4,678	7,025	( )	11,703
7.	Transportation vehicles	-		( )	-
8.	Intangible Asset	1,400	8,527	( )	9,927
9.	COVID Related	-	1,813	( )	1,813
10.	TOTAL CAPITALIZED COST . .	$27,431	$28,131	($-)	$55,562

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	Straight Line (Per AHA)	356	2,474	( )	2,830
14.	Fixed equipment		-		( )	-
15.	Moveable equipment	Straight Line (Per AHA)	208	1,502	( )	1,710
16.	Transportation vehicles		-		( )	-
17.	Intangible Asset	Straight Line (Per AHA)	23	2,814	( )	2,837
18.	COVID Related	Straight Line (Per AHA)	-	30	( )	30
19.	TOTAL ACCUMULATED DEPRECIATION		$587		($-)	$7,407
20.	**TOTAL DEPRECIATION EXPENSE**			**$6,820**		

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

Medicaid PopID & Provider Number 766-100089231

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	$237,000		( )	$237,000
2. Land Improvements	-		( )	-
3. Buildings	948,000		( )	948,000
4. Leasehold Improvements			( )	-
5. Fixed equipment			( )	-
6. Moveable equipment			( )	-
7. Transportation vehicles			( )	-
8.			( )	-
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$1,185,000	$-	($-)	$1,185,000

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	Straight Line (Per AHA)	22,120	37,920	( )	60,040
13. Leasehold Improvements				( )	-
14. Fixed equipment				( )	-
15. Moveable equipment				( )	-
16. Transportation vehicles				( )	-
17.				( )	-
18.				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$22,120		($-)	$60,040
20. TOTAL DEPRECIATION EXPENSE			**$37,920**		

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

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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.	Oconto Property LLC	[x] Yes [ ] No	[ ] Yes [x] No		Jun-19	Nursing Home	$218,112
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.	Synapse	[ ] Yes [x] No	[ ] Yes [x] No		Jan-20	Mattresses, Wheelchair	$395
5.	Culligan	[ ] Yes [x] No	[ ] Yes [x] No		Jan-20	Water Coolers	139
6.	Reliable Water	[ ] Yes [x] No	[ ] Yes [x] No		Jan-20	Hot Water Heaters	4,512
7.	Paycom	[ ] Yes [x] No	[ ] Yes [x] No		Jan-20	Timeclock	1,800
8.	TIAA	[ ] Yes [x] No	[ ] Yes [x] No		Jan-20	Copiers/Printers	16,445
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 **$241,403**

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	$31,428
2. 2020 Personal Property Tax Bill	1,112

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

Date(s) paid 2/5/2021 Amount(s) paid $31,540 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 [x] 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 $32,540

Medicaid PopID & Provider Number 766-100089231

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 766-100089231

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**			
1.	Property insurance (s31)	$10,187	$10,187			
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)	-				
7.	Depreciation leasehold improve. (s34)	2,474	2,474			
8.	Depreciation fixed equipment (s34)	-				
9.	Depreciation moveable equip. (s34)	1,502	1,502			
10.	Depreciation transportation veh. (s34)	-				
11.	Depreciation other (s34)	2,844	2,844			
12.	Expense on operating leases (s35)	241,403	241,403			
13.	Expense on capitalized leases (s36)	-				
14.	Property taxes or fees (s37)	32,540	32,540			
15.	TOTAL EXPENSE	$290,950	$290,950			
16.	Less total directly assigned property exp.	$290,950				
17.	**NET UNASSIGNED/INDIRECT PROP. . . . .**	**$-**				
SECTION B - NON-SALARY EXPENSES		**A. Total From Sched.**	**B. NH Area**			
18.	Square feet of service's building area	33,725	33,725			
19.	Ratio to total square feet to 4 decimals	1.0000	1.0000			
20.	Indirect property expense allocation	$- (from 17A)	- 20A x 19B	- 20A x 19C	- 20A x 19D	- 20A x 19E
SECTION C - TOTAL		**A. Total From Sched.**	**B. NH Area**			
21.	**TOTAL PROP. EXP. FOR EACH AREA**	**$290,950** 17A + 20 A	**$290,950** 15B + 20B	**$-** 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.
All capital assets are recorded at historical cost as of the date acquired. Tangible assets falling below the $1,000 threshold are recorded as an expense on the financial statements. Assets with economic useful life of 12 months or less are required to be expensed for financial statement purposes, regardless of the acquisition or production cost. All capital property will be depreciated using the straight-line method.

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

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

SECTION A - RELATED PARTY LEASES

	A. Description of Expense Item	Location and Amount of Expense Included in This Cost Report				
		B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Net Expense
1.	Total related party lease expense					
2.	Insurance expense					
3.	Amortization deferred expense					
4.	Interest expense	A&G	33RP	H	15	98,753
5.	Depreciation expense	A&G	34RP	C	20	37,920
6.	Property tax expense					
7.						
8.						
9.	SUBTOTAL FOR RELATED PARTY LEASES					$136,673

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10.	Rent	A&G	35	G	1	$218,112
11.						
12.						
13.						
14.						
15.	**TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)**					$354,785

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.

Oconto Property Company

Medicaid PopID & Provider Number 766-100089231

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	$8,691	A&G	26	E	11
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	222	A&G	26	E	11
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 766-100089231

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.									

SCHEDULE 49: Percentage of Ownership

	Name of Individual or Entity	Percentage of Ownership
1.	Menachem Ruvel	25%
2.	Yisroel Weinberg	25%
3.	Benjamin Landa	25%
4.	Howard Fensterman	25%
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.	See Attached Schedule	Skilled Nursing Facility	Common Ownership
2.			
3.			
4.			
5.			

SCHEDULE 51 - NO LONGER USED

Medicaid PopID & Provider Number 766-100089231

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 766-100089231

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 The Bay at Oconto Health and Rehab. Center 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