WISCONSIN MEDICAID PROGRAM 2018 NURSING HOME COST REPORT

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

SCHEDULE 1 - FACILITY AND PREPARER INFORMATION AND CERTIFICATION

SECTION A - FACILITY INFORMATION

Facility Name	Main Telephone Number	Main E-Mail Address	
Kenosha Estates	262-658-4125	administrator@kenoshaestatesrcc.com	
Facility Street Address	**City**	**State**	**Zip Code**
1703 West 60th St	Kenosha	WI	53140

Contact Person	Contact Telephone Number	Contact E-Mail Address	Corporate Facility Number
Brian Levinson	841-329-4100 x1018	brian@jbhcc.com	

Cost Report Period Start Date	Cost Report Period End Date	Medicaid Provider Number	National Provider Identifier (NPI)	POP ID Number
1/1/2018	12/31/2018	100041939	1609173590	811

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Lauren Beaumont	Brian Levinson	At the facility

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

Name and Title		Telephone Number	
Wipfli LLP		414-431-9335	
Address	**City**	**State**	**Zip Code**
10000 Innovation Drive, Suite 250	Milwaukee	WI	53226
SIGNATURE - Original Signature of Preparer		Date Signed	

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

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

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

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

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

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SCHEDULE 2 - PROVIDER'S NOTES, COMMENTS AND QUALIFICATIONS REGARDING THE MEDICAID NURSING HOME COST REPORT

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

Commentator's Name	Title	Date

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SCHEDULE 3 - GENERAL INFORMATION

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

2. Type of license (check all that apply) — [X] (01) Skilled Nursing; [ ] (20) Developmentally Disabled; [ ] (10) Intermediate Care; [ ] (40) IMD

3. Type of ownership (check one) — [X] (1) Proprietary; [ ] (2) Voluntary Non-Profit; [ ] (3) Governmental

4. County of facility: Kenosha — County Code: 30

5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed. — [ ] (1) Yes [X] (2) No

6. Does the facility provide laundry services to residents for personal clothing? — [X] (1) Yes [ ] (2) No

7. Are any employees of the facility covered by a union contract? — [X] (1) Yes [ ] (2) No

8. Is the facility Medicare (Title XVIII) certified? — [X] (1) Yes [ ] (2) No

9. Fiscal Year Beginning Month: Jan — Fiscal Year Ending Month: Dec

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

	DATE	BEDS
Beds at Beginning of Cost Reporting Period	1/1/2018	97
Beds at End of Cost Reporting Period	12/31/2018	97

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

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

12. 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

13A. A final adjusted trial balance for the cost reporting period, including a reconciliation of the trial balance to the cost report must be submitted with this cost report. Have copies been made and included with this cost report? — [X] Yes [ ] No

13B. Asset depreciation schedules detailing amounts reported on Schedule 34 - Depreciation expenses must be submitted. Have copies been made and included with this cost report? — [X] Yes [ ] No

14. Single occupancy rooms: On the right side of the license effective on the last day of the cost report period, you will find the capacity of 1 BED, 2 BED, 3 BED, and 4 BED rooms. Add the number of beds labeled 1 BED and enter it in column C (Single-Bed Rooms). Add the number of beds on all other lines and enter it in column D (Beds in Multiple-Bed Rooms). Add the number of beds in single rooms (column C) to the number of beds in multiple-bed rooms (column D) and enter the total in Column E (Total Licensed Beds). This total must agree with the maximum capacity shown on your license. If your facility has more than one license, list each license on a separate line and total for each column.

	A. NAME	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1.	Kenosha Estates	0	7	90	97
2.					-
3.					-
4.	TOTAL		7	90	97

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SCHEDULE 4 - MAJOR REVENUE GENERATING ACTIVITIES

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

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SCHEDULE 5 - BUILDING SQUARE FOOTAGE

SECTION A - GENERAL INFORMATION	WING A	WING B	WING C	WING D
Name or description of building or wing	SNF			
Year construction was functionally completed on building or wing	1970			
Total square footage of building or wing	25,330			
SECTION B - NURSING HOME SERVICE AREAS				
1. Nuns or other employees' housing				
2. Employees' unique fringe benefit areas				
3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup)	2,936			
4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.)	1,659			
5. Laundry (washing/drying room, sorting/folding rooms, central linen storage)	529			
6. Administration (general/accounting offices, reception areas, meeting rooms)	1,978			
7. Laboratory & radiology				
8. Pharmacy				
9. Physical therapy	2,167			
10. Occupational therapy	619			
11. Other therapies	310			
12. Beauty and barber shops	298			
13. Gift shop, canteen, snack shop				
14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.)	14,834			
SECTION C - RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY				
15. Hospital direct patient service areas				
16.				
17.				
18.				
SECTION D - OTHER AREAS				
19. Major idle or closed areas				
20. Residual unidentified square footage (Total area less lines 1 through 19)				

Describe general purpose or use of Line 20 square footage:

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SCHEDULE 6 - TOTAL PATIENT DAYS

SECTION A - INHOUSE PATIENT DAYS	LEVEL OF CARE (LOC) NON DD	DD	TOTAL
1a. Medicaid (T-19)	13,122		13,122
1b. ICF-IID Medicaid (T-19)			-
1c. Family Care (T-19)	5,925		5,925
1d. Other Medicaid Managed Care (T-19)			-
1e. Hospice (T-19)	1,276		1,276
1f. Ventilator (T-19)			-
2a. Medicare (T-18)	2,305		2,305
2b. Medicare Advantage, for days covered as a Part A stay	1,434		1,434
3a. Private pay & Insurance	1,296		1,296
3b. Medicare Advantage, for days not covered as a Part A stay			-
3c. Hospice (Private pay & Insurance)			-
4. Other, Specify: WI State Mandate	52		52
5. TOTAL INHOUSE PATIENT DAYS	25,410	-	25,410

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 (lines 5 + 8)	**25,410**	**-**	**25,410**

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SCHEDULE 7 - NO LONGER USED

Information is now on Schedule 6

SCHEDULE 8 - TOTAL PATIENT DAYS BY MONTH

(Required)

1.	MONTH	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	**TOTAL**
2.	Days in Month	31	28	31	30	31	30	31	31	30	31	30	31	365
3.	Licensed Beds for Bed Hold Testing. . . .	97	97	97	97	97	97	97	97	97	97	97	97	1,164
4.	Occupancy Test:													
	Row 2 X (Row 3 X 94%)	2,827	2,553	2,827	2,735	2,827	2,735	2,827	2,827	2,735	2,827	2,735	2,827	33,282
5.	Inhouse patient days	2,391	2,328	2,397	2,365	2,254	2,135	2,099	1,963	1,783	1,814	1,900	1,981	25,410
6.	Bed Hold days	-	-	-	-	-	-	-	-	-	-	-	-	-
7.	**TOTAL DAYS . . .**	2,391	2,328	2,397	2,365	2,254	2,135	2,099	1,963	1,783	1,814	1,900	1,981	25,410

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

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

SCHEDULE 9A - HOSPICE PATIENT DAYS - NO LONGER USED

Information is now on Schedule 6

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

Information is now on Schedule 6

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SCHEDULE 10 - BALANCE SHEET

ASSETS	Begin Date 1/1/18	End Date 12/31/18
CURRENT ASSETS		
Cash on hand and in bank	$ (43,091)	$ (115,213)
Temporary investments		
Resident accounts receivable	729,626	649,318
Other accounts receivable		
Due from related parties		
Notes receivable		
Accrued interest receivable		
Inventories		
Prepaid expenses	71,461	62,225
Resident funds held in trust		
Other current assets, list below:		
TOTAL CURRENT ASSETS	$ 757,996	$ 596,330
PROPERTY, PLANT, EQUIP.		
Land		
Land improvements		
Buildings		
Leasehold improvements	6,238	29,413
Fixed equipment		
Moveable equipment	28,352	28,352
Transportation equipment		
Other		
Less: accumulated depreciation	(12,152)	(16,673)
TOTAL PROPERTY, PLANT, EQUIPMENT	$ 22,438	$ 41,092
OTHER		
Long term investments		
Other Assets, list below:		
deposits	15,288	15,288
TOTAL OTHER ASSETS	$ 15,288	$ 15,288
TOTAL ASSETS	$ 795,722	$ 652,710

LIABILITIES AND OWNERS' EQUITY	Begin Date 1/1/18	End Date 12/31/18
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Notes Payable	$ 651,188	$ 537,622
Due to related parties	339,066	423,941
Accounts payable	1,483,133	1,724,023
Accrued salaries	131,536	133,198
Other accrued expenses	762,191	760,318
Resident trust funds payable		
Other current liabilities		
TOTAL CURRENT LIABILITIES	$ 3,367,114	$ 3,579,102
LONG TERM LIAB.		
Notes and loans payable (list) below:		
Other long term liabilities		
TOTAL LONG TERM LIABILITIES	$ -	$ -
OWNER EQUITY		
OWNERS' EQUITY, list below:		
retainted earnings	(1,844,320)	(2,587,174)
current year profit (loss)	(727,072)	(339,218)
TOTAL OWNER'S EQUITY	$ (2,571,392)	$ (2,926,392)
TOTAL LIABILITIES AND EQUITY	$ 795,722	$ 652,710

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SCHEDULE 10A - SUMMARY OF CHANGES IN OWNERS' EQUITY

1.	Beginning Owners' Equity (from schedule 10)			$ (2,571,392)
2.	Add	Net income (from schedule 11, line 21)	$ -	
		Owners' capital contribution		
		County appropriation		
		Net decrease in accrued vacation, holiday and sick time		
		Other, Specify:		
		Other, Specify:		
		Total additions		-
3.	Deduct	Net loss (from schedule 11, line 19)	($ 336,113)	
		Dividends and withdrawals	(15,784)	
		Net increase in accrued vacation, holiday and sick time	( )	
		Other, Specify: adjust to personal property tax bill	(3,103)	
		Other, Specify:	( )	
		Total deductions		(355,000)
4.	**ENDING OWNERS' EQUITY (schedule 10).**			$ (2,926,392)

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SCHEDULE 11 - SUMMARY OF REVENUES AND EXPENSES

All values are automatically posted from other schedules.

SECTION A - SUMMARY OF REVENUE

1.	Daily patient service revenue	schedule 14, lines 1-4	$	5,351,691
2.	Service fees	schedule 15, line 14A		998,352
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		-
7.	Rental revenues	schedule 17, line 21A		-
8.	Revenues from other major activities	schedule 17, line 37		-
9.	Sales to related organizations	schedule 18, line 41		-
10.	Investment revenue	schedule 18, line 45		-
11.	Gains (Losses) on disposal of assets	schedule 18, line 47		-
12.	Grants for government-subsidized employees	schedule 18, line 48		-
13.	Grants, contributions, donations	schedule 18, line 49		-
14.	Other revenue	schedule 18, line 54		646
15.	Subtract: deductions from revenues	schedule 14, line 5		(620,478)
16.	NET REVENUES		$	5,731,169

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 38	$	(6,067,282)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15		-
19.	**NET INCOME OR LOSS**		$	**(336,113)**

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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	$ 2,232,111
2. Laboratory & Radiology	S21, L15a	17,201
3. Respiratory	S21, L15b	-
4. Pharmacy	S21, L15c	77,168
5. PT, OT and Speech	S22, L15a	678,085
6. Dental	S22, L15b	-
7. Physician	S22, L15c	30,000
8. Social Services	S23, L15a	23,491
9. Recreational Activities	S23, L15b	120,566
10. Religious Services	S23, L15c	-
11. Volunteer Coordinator	S24, L15a	-
12. Ward Clerks	S24, L15b	-
13. Psychotherapy	S24, L15c	-
14. Other	S24, L15d	
15. Dietary	S25, L19a	455,782
16. Plant Operations and Maintenance	S25, L19b	147,816
17. Housekeeping	S25, L19c	117,264
18. Laundry and Linen	S25, L19d	55,801
19. Security	S25, L19e	-

Cost Center	Reference	Expense
20. Transportation	S25, L19f	$ -
21. Administrative service expense	S26, L12	1,235,001
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L15a	
23. Beauty/Barber Shop	S27, L15b	
24. 0	S27, L15c	
25. 0	S27, L15d	
26. 0	S27, L15e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	518,036
28. Heating fuel and utility expense	S29, L10	101,877
29. Interest on operating working capital loans	S30, L6	54,754
30. Insurance expense	S31, L9	82,347
31. Amortization expense	S32, L5	-
32. Interest on plant asset loans	S33, L15h	-
33. Depreciation expense	S34, L20c	4,521
34. Expense on operating and non-cap.leases	S35, L14	112,554
35. Expense on capitalized leases	S36A, L5	-
36. Property tax expense	S37, L9	2,907
37. Other non-salary expense	S39, L4	-
38. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38). .		$ 6,067,282

(To schedule 11, line 17)

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SCHEDULE 13 - SUMMARY OF SALARY AND WAGE EXPENSES

All values are automatically posted from other schedules.

Cost Center and Schedule		Total Salary and Wage Expense (Line 1 or 5)
Daily patient service	S20, L1e	$ 1,883,578
Laboratory & Radiology	S21, L1a	-
Respiratory	S21, L1b & 3b	-
Pharmacy	S21, L1c & 3c	-
PT, OT and Speech	S22, L1a &3a	41,070
Dental	S22, L1b &3b	-
Physician	S22, L1c &3c	-
Social Services	S23, L3a	6,713
Recreational Activities	S23, L3b	93,977
Religious Services	S23, L3c	-
Volunteer Coordinator	S24, L1a & 3a	-
Ward Clerks	S24, L1b & 3b	-
Psychotherapy	S24, L1c & 3c	-
Other	S24, L1d & 3d	-

Cost Center and Schedule			Total Salary and Wage Expense (Line 1 or 5)
Dietary	S25, L1a		196,280
Plant operation / maintenance	S25, L1b		52,170
Housekeeping	S25, L1c		102,160
Laundry and Linen	S25, L1d		45,136
Security	S25, L1e		-
Transportation	S25, L1f		-
Administrative service	S26, L1e		435,015
Nurse aide training	S27, L1a		-
Beauty and barber	S27, L1b		-
Other, Specify: 0	S27, L1c		-
0			-
0			-
TOTAL SALARY AND WAGE EXPENSE			$ 2,856,099

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SCHEDULE 14 - DAILY PATIENT SERVICE REVENUES

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

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$1,072,947
2. Medicaid Daily Rate (including bed hold)	3,081,060
3. Private Pay	303,404
4. Medical Supplies,Other	894,280
SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(620,478)
SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$ 4,731,213

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 $244.00
8. Facility Comment (Optional)

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SCHEDULE 15 - SPECIAL SERVICE REVENUES

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

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

SECTION A - SERVICE REVENUES

		A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1.	Laboratory	$ 19,733			
2.	Radiology				
3.	Pharmacy	123,175			
4.	Physical therapy	329,053			
5.	Speech/hearing therapy	233,193			
6.	Occupational therapy	293,198			
7.	Physician care				
8.	Psychotherapy				
9.	Respiratory therapy				
10.	Social services				
11.	Recreational activities				
12.	Special duty nursing				
13.	Other, Specify:				
14.	TOTAL SPECIAL SERVICE REVENUE	$ 998,352	$ -	$ -	

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

SECTION B - THERAPY REVENUES

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

16. Total gross revenues for physical, occupational, and speech therapy services provided at your facility during the cost report period $ 855,444
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) $ 855,444

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	$	88,012
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/surpl	
2.	Dietary supplies sold		Cost of dietary supplies sold (if known)	
3.	Meals sold to employees (transfer to sched. 25A, line 10)			
4.	Meals On Wheels			
5.	Other Meals Sold			
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					
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**	**$ -**				

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SCHEDULE 17 - OTHER REVENUES

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

SECTION C - 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				
21a. TOTAL RENTAL REVENUES	**$ -**			

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

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SCHEDULE 18 - OTHER REVENUES

SECTION E - SALES TO RELATED ORGANIZATIONS	Revenue
38.	
39.	
40.	
41. TOTAL SALES TO RELATED ORGANIZATIONS	$ -

SECTION F - INTEREST AND INVESTMENT REVENUE	Revenue
42. Revenues from invested gift/grant funds not commingled with other funds	
43. Revenue from invested funds used for current cash needs	958
44. Other revenue from invested funds	
45. TOTAL INVESTMENT REVENUE	$ -

46. If total investment revenue exceeds $6,000, describe major investments (type, invested amount, purpose if any)

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

SECTION H - GRANTS FOR GOVT. SUBSIDIZED EMP.	Revenue
48. TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES	

SECTION I - GRANTS, CONTRIBUTIONS, DONATIONS	Revenue
49. TOTAL GRANTS, CONTRIBUTIONS, DONATIONS	

SECTION J - OTHER REVENUES	Revenue
50. Other Revenue	$ 646
51.	
52.	
53.	
54. TOTAL OTHER REVENUES	$ 646

Medicaid PopID & Provider Number 811-100041939

SCHEDULE 20 - DAILY PATIENT SERVICE EXPENSE

SALARIES, WAGES PURCHASED SERV.	A. Registered Nurses	B. Licensed Practical Nurses	C. Nurse Aides and Assistants	D. Resident Living Staff	E. Total Expense/Hrs. (sum A-D)
1. TOTAL SALARY AND WAGE EXPENSE	$ 587,507	$ 511,096	$ 784,975		$ 1,883,578
2. TOTAL SALARY AND WAGE HOURS	15,577 hrs.	18,574 hrs.	56,945 hrs.		$ 91,096
3. EXPENSE FOR PURCHASED SERVICES	$ (1,739)	$ 7,363	$ 1,927		$ 7,551

NURSING AND INCONTINENCY SUPPLIES	
4. Catheters, Incontinency Supplies (including purchased laundry service	$ 29,808
OXYGEN	
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental	4,057
OTHER	
6. Other medical supplies, personal comfort supplies and minor medical equipment	144,287
7. Nonbillable over the counter (OTC) drugs for all residents (include other OTC drugs billable on drug claim forms schedule 21, line 11)	27,442
8. Other Nursing Supplies	135,388
9.	
10. TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 1, 3, 4-9)	**$ 2,232,111**

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SCHEDULE 21 - SPECIAL SERVICE EXPENSES

SECTION A - SALARY AND WAGES	TYPE OF SERVICE 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	$ 17,201		
7. Number of hours of purchased service - Billable (optional)			
8. Expense for purchased service - Non billable	$ -		$ 6,163
9. Number of hours of purchased service - Non billable (optional)	hrs.		
SECTION C - SUPPLY AND OTHER EXPENSE			
10. Pharmacy - legend drugs Billable	$ -	$ -	71,005
11. Pharmacy - over the counter drugs Billable	$ -	$ -	
12. Supply and Other			
13.			
14.			
SECTION D - TOTAL			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	**$ 17,201**	**$ -**	**$ 77,168**
16. TOTAL HOURS (Sum 2, 4, 7, 9)	**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.	$ 41,070		
2.	Number of hours worked - Billable.	1,283 hrs.		
3.	Expense for hours worked - Non-billable.			
4.	Number of hours worked - Non-billable.			
5.	TOTAL SALARY AND WAGE EXPENSE	$ 41,070	$ -	$ -
	SECTION B - PURCHASED SERVICES			
6.	Expense for purchased service - Billable	$ 636,563		
7.	Number of hours of purchased service - Billable (optional)			
8.	Expense for purchased service - Non billable			$ 30,000
9.	Number of hours of purchased service - Non billable (optional). . .			
	SECTION C - SUPPLY AND OTHER EXPENSE			
10.	Supplies	452		
11.				
12.				
13.				
14.				
	SECTION D - TOTAL			
15.	TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	$ 678,085	$ -	$ 30,000
16.	TOTAL HOURS (Sum 2, 4, 7, 9)	1,283 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	$ 6,713	$ 93,977	
4. Number of hours worked - Non-billable	360 hrs.	7,401 hrs.	
5. TOTAL SALARY AND WAGE EXPENSE	$ 6,713	$ 93,977	$ -
SECTION B - PURCHASED SERVICES			
6. Expense for purchased service - Billable	$ -	$ -	$ -
7. Number of hours of purchased service - Billable (optional)	hrs.	hrs.	hrs.
8. Expense for purchased service - Non billable	$ 16,778		
9. Number of hours of purchased service - Non billable (optional) . .			
SECTION C - SUPPLY AND OTHER EXPENSE			
10. Supplies		$ 26,589	
11.			
12.			
13.			
14.			
SECTION D - TOTAL			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14)	**$ 23,491**	**$ 120,566**	**$ -**
16. TOTAL HOURS (Sum 2, 4, 7, 9)	**360 hrs.**	**7,401 hrs.**	**hrs.**

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SCHEDULE 24 - OTHER TYPES OF 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.	Number of hours of purchased service - Billable (optional)				
8.	Expense for purchased service - Non billable				
9.	Number of hours of purchased service - Non billable (optional) . .				
SECTION C - SUPPLY AND OTHER EXPENSE					
10.					
11.					
12.					
13.					
14.					
SECTION D - TOTAL					
15.	**TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . . .**	$ -	$ -	$ -	
16.	**TOTAL HOURS (Sum 2, 4, 7, 9) . . . . . .**	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	$ 196,280	$ 52,170	$ 102,160	$ 45,136		
2. NUMBER OF HOURS WORKED	16,643 hrs.	2,983 hrs.	9,539 hrs.	3,969 hrs.		
Lines 3-5 are no longer used						
SECTION B - DIETICIAN CONSULTANT						
6. Dietician consultant expense	$ 14,220	$ -	$ -	$ -	$ -	$ -
Line 7 is no longer used						
SECTION C - OUTSIDE SERVICE						
8. Purchased Services		$ 94,142				
9.						
10.						
11.						
12. **TOTAL OUTSIDE SERVICE EXPENSES**	$ -	$ 94,142	$ -	$ -	$ -	$ -
SECTION D - No longer used						
SECTION E - SUPPLY AND OTHER EXPENSE						
13. Supplies	$ 245,282	$ 1,504	$ 15,104	$ 10,665		
14.						
15.						
16.						
17.						
SECTION F - No longer used						
SECTION G - TOTAL						
18. TOTAL EXPENSES ..... **(Sum 1, 6, 8-11, 13-17)**	**$ 455,782**	**$ 147,816**	**$ 117,264**	**$ 55,801**	**$ -**	**$ -**

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

SECTION A - ALLOCATION OF DIETARY EXPENSES

1.	Total dietary expenses (from schedule 25, line 18)	$ 455,782
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)	$ 455,782

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other
6.	Meals served	76,230	76,230				
7.	Ratio to total meals served to 4 decimals	1.0000	1.0000				
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$ 455,782 (From line 5)	$ 455,782 (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	25,330	25,330				
13.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000				
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$ 147,816 (From S25, L18)	$ 147,816 (14A X 13B)	$ - (14A X 13C)	$ - (14A X 13D)	$ - (14A X 13E)	$ - (14A X 13F)

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

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	25,530	25,530			
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$ 117,264	$ 117,264	$ -	$ -	$ -
		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	100	100			
19.	Ratio to total pounds to 4 decimals	1.0000	1.0000			
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.	$ 55,801	$ 55,801	$ -	$ -	$ -
		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

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SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES

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

SECTION A - SALARY AND WAGES	A. General Admin. Serv.	B. Medical Records	C. Central Supply	D.Accounting/Other Serv.	E. TOTAL (sum A-D)
1. TOTAL SALARY AND WAGE EXPENSE	$ 109,255	$ 92,437		$ 233,323	$ 435,015

SECTION B -RELATED ORGANIZATION CENTRAL SERVICE COSTS

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

SECTION C - NON-SALARY EXPENSES

8.	Purchased services - legal	$ 10,857
9.	Licensed bed assessment	197,900
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	591,229

SECTION D - TOTAL

12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES (Sum 1, 6-11)	$ 1,235,001

SECTION E - HOME OFFICE COST ALLOCATION REPORT

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office.

A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office _____ From (date) _____ through (date) _____

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SCHEDULE 26 - ADMINISTRATIVE SERVICE EXPENSES - RELATED PARTY

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

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

SECTION B -RELATED ORGANIZATION CENTRAL SERVICE COSTS

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

SECTION C - NON-SALARY EXPENSES

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

SECTION D - TOTAL

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

SECTION E - HOME OFFICE COST ALLOCATION REPORT

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to the Regional Auditor's office.

A county facility can base the county centralized service costs allocated to the facility on the countrywide cost allocation plan. A separate Home Office Cost Allocation Report does not need to be completed.

Name of home office _____ From (date) _____ through (date) _____

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SCHEDULE 26 ATTACHMENT - OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Advertising Expense	$ 20,961
2.	Administrative Contracted Service	127,593
3.	Administrative Consulting Expense	1,390
4.	Adminstrative Supplies	9,945
5.	License & Permits	(329)
6.	Postage	1,966
7.	Small Equipment	1,838
8.	Telephone Expense	15,505
9.	Travel	14,561
10.	Automobile	4,063
11.	Other Administrative Expense	393,736
12.		
13.		
14.		
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (Should equal schedule 26, line 11) . . . . . .**	**$ 591,229**

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

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

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

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SCHEDULE 26B - ALLOCATION OF ADMINISTRATIVE EXPENSES

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

1. Total Admin. Service Expense (S26, 12) $ 1,235,001

SECTION A - DIRECT EXPENSES

	Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	Non-Nursing Home Areas Receiving Administrative Services		
2.	All Admin	$ (1,235,001)	$ 1,235,001			
3.		-				
4.		-				
5.		-				
6.		-				
7.		-				
8.		-				
9.		-				
10.		-				
11.		-				
12.		-				
13.		-				
14.		-				
15.	TOTAL DIRECT EXP. (sum 2-14)	$ (1,235,001)	$ 1,235,001			
16.	NET UNASSIGNED EXP. (line 1-line 15)	$ -				

SECTION B - ALLOC. OF INDIRECT EXP.

		A. Total	B. NH Provider			
17.	Allocation basis amounts	25,330	25,330			
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	$ 1,235,001 (line 15A + 19A)	$ 1,235,001 (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. NUMBER OF HOURS WORKED					

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

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	-	-	-
16. TOTAL EXPENSES (Sum 1, 3-14)					

Medicaid PopID & Provider Number 811-100041939

SCHEDULE 28 - EMPLOYEE FRINGE BENEFIT EXPENSES

INSTRUCTIONS: Under the column labeled "Self-Funded", indicate yes or no. If yes, attach documentation to support the amount claimed for each self-funded benefit by completing and saving the "Sch 28 Self Funded FB" worksheet.

SECTION A - FRINGE BENEFITS PAID ON BEHALF OF EMPLOYEES

	Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1.	Employer's share of F.I.C.A.		$ 211,409
2.	State unemployment compensation		44,067
3.	Federal unemployemnt compensation		5,265
4.	Worker's compensation insurance	☐ Yes ☒ No	152,942
5.	Health, Dental & Vision Insurance	☐ Yes ☒ No	101,927
6.	Life and disability insurance	☐ Yes ☐ No	
7.	Wage continuation insurance	☐ Yes ☐ No	
8.	Pension and deferred comp. plans (section C)	☐ Yes ☐ No	
9.	Employee physicals and vaccines (if pre-employment, report costs on Sch 26-Attachment)		72
10.	Uniforms		
11.	Other Benefits		2,354
12.			
13.			
14.			
15.	TOTAL PAID ON BEHALF OF EMPLOYEES (sum 1-14)		$ 518,036
16.	Expense for special salary or wage payments to employees not lincluded elsewhere (section D)		
17.	**TOTAL FRINGE BENEFIT EXPENSE(sum 15+16)**		**$ 518,036**

SECTION D - SPECIAL SALARY AND WAGE PAYMENTS TO EMPLOYEES

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

☐ Christmas bonus ☐ Longevity bonus ☐ Productivity bonus ☐ Other, Specify:

☐ Bonuses to owners and immediate family relations, Specify:

Self-Funded Fringe Benefit Worksheet

Complete this form if you indicated any self-funded fringe benefits on Schedule 28. Press Ctrl-Shift-K to save this worksheet as a separate supporting document.

Facility Name **Kenosha Estates**

Cost Report Period **1/1/2018** **12/31/2018**

	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 FUEL AND UTILITY EXPENSES

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

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

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

Cost allocation: In section B, allocate the fuel and utility expense between the Medicaid nursing home area and other major revenue-generating areas or non-nursing home areas. Describe the allocation technique if an allocation basis other than square footage is used. The allocation basis used is similar to the maintenance allocation on schedule 25A.

SECTION A - ACCRUED EXPENSE BY TYPE

	Expense by Type	Accrued Expense		Expense by Type	Accrued Expense
1.	Fuel oil		6.	Water and sewer utility charges	17,453
2.	Natural gas	22,533	7.	Purchased steam	
3.	L.P. gas		8.		
4.	Coal		9.		
5.	Electricity	61,891	**10.**	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$ 101,877**

SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE

		A. Total	B. NH Area	C. Emp. Unique Fringe Ben. Area	Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.		
11.	Total square feet for areas	25,330	25,330				
12.	Ratio to total square feet to 4 decimals	1.0000	1.0000				
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**101,877**	**$ 101,877**	**$ -**	**$ -**	**$ -**	**$ -**
		From line 10	13A X 12B	13A X 12C	13A X 12D	13A X 12E	13A X 12F

Medicaid PopID & Provider Number 811-100041939

SCHEDULE 30 - INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS

	Name of Lender	Is Lender a Related Party?	Interest Expense
1a.	Leumi	b. [ ] Yes [X] No	$ 54,754
2a.		b. [ ] Yes [ ] No	
3a.		b. [ ] Yes [ ] No	
4a.		b. [ ] Yes [ ] No	
5a.		b. [ ] Yes [ ] No	
6.	**TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5)**		**$ 54,754**

SCHEDULE 31 - INSURANCE EXPENSES

	Type of Insurance Coverage	Self-Funded?	Insurance Expense
1.	Property insurance on building and contents	[ ] Yes [X] No	$ 14,787
2.	Automobile insurance	[ ] Yes [ ] No	
3.	Liability insurance	[ ] Yes [X] No	67,560
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.**		**$ 82,347**

SCHEDULE 32 - AMORTIZATION OF DEFERRED EXPENSES

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

Medicaid PopID & Provider Number 811-100041939

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

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

SCHEDULE 31 - INSURANCE EXPENSES - RELATED PARTY

	Type of Insurance Coverage	Self-Funded?	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 32 - AMORTIZATION OF DEFERRED EXPENSES - RELATED PARTY

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

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SCHEDULE 33 - INTEREST EXPENSES ON PLANT ASSET LOANS

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.	G. Interest Rate	H. Interest Expense
1a. Name								
1b. Related party? ☐ Yes ☐ No								
1c. Purpose								
2a. Name								
2b. Related party? ☐ Yes ☐ No								
2c. Purpose								
3a. Name								
3b. Related party? ☐ Yes ☐ No								
3c. Purpose								
4a. Name								
4b. Related party? ☐ Yes ☐ No								
4c. Purpose								
5a. Name								
5b. Related party? ☐ Yes ☐ No								
5c. Purpose								
6a. Name								
6b. Related party? ☐ Yes ☐ No								
6c. Purpose								
7a. Name								
7b. Related party? ☐ Yes ☐ No								
7c. Purpose								
15 TOTAL LOAN PRINCIPAL				$ -	$ -	$ -	**TOTAL EXP.**	$ -

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

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.	G. Interest Rate	H. Interest Expense
8a. Name								
8b. Related party? ☐ Yes ☐ No								
8c. Purpose								
9a. Name								
9b. Related party? ☐ Yes ☐ No								
9c. Purpose								
10a. Name								
10b. Related party? ☐ Yes ☐ No								
10c. Purpose								
11a. Name								
11b. Related party? ☐ Yes ☐ No								
11c. Purpose								
12a. Name								
12b. Related party? ☐ Yes ☐ No								
12c. Purpose								
13a. Name								
13b. Related party? ☐ Yes ☐ No								
13c. Purpose								
14a. Name								
14b. Related party? ☐ Yes ☐ No								
14c. Purpose								
16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY				$ -	$ -	$ -		$ -

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

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

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.	G. Interest Rate	H. Interest Expense
1a. Name								
1b. Related party? ☐ Yes ☐ No								
1c. Purpose								
2a. Name								
2b. Related party? ☐ Yes ☐ No								
2c. Purpose								
3a. Name								
3b. Related party? ☐ Yes ☐ No								
3c. Purpose								
4a. Name								
4b. Related party? ☐ Yes ☐ No								
4c. Purpose								
5a. Name								
5b. Related party? ☐ Yes ☐ No								
5c. Purpose								
6a. Name								
6b. Related party? ☐ Yes ☐ No								
6c. Purpose								
7a. Name								
7b. Related party? ☐ Yes ☐ No								
7c. Purpose								
15 TOTAL RELATED PARTY LOAN PRINCIPAL				$ -	$ -	$ -	**TOTAL EXP.**	$ -

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

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2018 Begin Bal.	E. 6Mo.date 6/30/2018 6 Mo. Bal.	F. End date 12/31/2018 End Bal.	G. Interest Rate	H. Interest Expense
8a. Name								
8b. Related party? ☐ Yes ☐ No								
8c. Purpose								
9a. Name								
9b. Related party? ☐ Yes ☐ No								
9c. Purpose								
10a. Name								
10b. Related party? ☐ Yes ☐ No								
10c. Purpose								
11a. Name								
11b. Related party? ☐ Yes ☐ No								
11c. Purpose								
12a. Name								
12b. Related party? ☐ Yes ☐ No								
12c. Purpose								
13a. Name								
13b. Related party? ☐ Yes ☐ No								
13c. Purpose								
14a. Name								
14b. Related party? ☐ Yes ☐ No								
14c. Purpose								
16 TOTALS FOR SCHEDULE 33, PAGE 2 ONLY				$ -	$ -	$ -		$ -

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

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SCHEDULE 34 - DEPRECIATION EXPENSES

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date / B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date / E. Ending Balance
	1/1/2018			12/31/2018
1. Land			( )	$ -
2. Land Improvements			( )	-
3. Buildings			( )	-
4. Leasehold Improvements	6,238	23,175	( )	29,413
5. Fixed equipment			( )	-
6. Moveable equipment	28,352	-	( )	28,352
7. Transportation vehicles			( )	-
8.			( )	-
9. .			( )	-
10. TOTAL CAPITALIZED COST . .	$ 34,590	$ 23,175	($ -)	$ 57,765

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date / B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date / E. Ending Balance
		1/1/2018			12/31/2018
11. Land Improvements		$ -		( )	$ -
12. Buildings		-		( )	-
13. Leasehold Improvements	straight line/various	2,986	1,248	( )	4,234
14. Fixed equipment		-		( )	-
15. Moveable equipment	straight line/various	9,166	3,273	( )	12,439
16. Transportation vehicles		-		( )	-
17.				( )	-
18. .		-		( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$ 12,152		($ -)	$ 16,673
20. TOTAL DEPRECIATION EXPENSE			**$ 4,521**		

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

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

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

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SCHEDULE 34 - DEPRECIATION EXPENSES - RELATED PARTY

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date 1/1/2018 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period (as negaive value)	End Date 12/31/2018 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 1/1/2018 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 12/31/2018 E. Ending Balance
11. Land Improvements		$ -		( )	$ -
12. Buildings	straight line per aha	-		( )	-
13. Leasehold Improvements	straight line per aha	-		( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment	straight line per aha	-		( )	-
16. Transportation vehicles		-		( )	-
17. .		-		( )	-
18. .		-		( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$ -		($ -)	$ -
20. TOTAL DEPRECIATION EXPENSE			**$ -**		

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

Include copies of invoices to support the cost of any Bariatric Equipment (see sec. 2.750 of Methods of Implementation for definition) purchases reported on Line 21.
Include a copy of your plant ledger that supports the amounts reported on this Schedule 34 - See Schedule 3 Line 13 B

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

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

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

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

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

	A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
1.		☐ 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. Month, Year acquired use	F. Describe Property	G. Lease Exp.
4.	Various	☐ Yes ☒ No	☐ Yes ☒ No		Jan-17	Various	$ 112,554
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 (sum 1-13) **$ 112,554**

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SCHEDULE 36A - LEASE EXPENSES ON CAPITALIZED LEASES

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

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

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

SECTION A - CAPITALIZED LEASE INFORMATION

Lease Expense

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 (sum 1a-1c)

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 (sum 2a-2c)

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 (sum 1a-1c)

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 (sum 1a-1c)

5. TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD - Transfer to Schedule 12 (sum 1d+2d+3d+4d) . . . . . $ -

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SCHEDULE 36B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

INSTRUCTIONS:

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

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor _____ 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 (sum A2+B2+C2+D2) . . . . . $ -

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SCHEDULE 37 - PROPERTY TAX EXPENSES

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

SECTION A - FOR ALL PROVIDERS — **Expense**

1. 2018 real estate tax (due in 2019) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.) — $ 2,907
2. 2018 personal property tax (due in 2019) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.)

3a. Have the amounts reported on lines 1 and 2 been paid in full? [x] 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. 2016 or 2017? [ ] Yes, explain below [x] No

Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____

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

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2018.
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule. Attach a copy of the bill.

Cost center name _____ Schedule number _____ Line number _____ Amount reported _____

6. The facility began to pay municipal service fees (check one) [ ] Prior to January 2018 [ ] On or after January 2018 Date began paying fees _____
7. Describe the services provided by the municipality for the above fees. _____
8. Payment of the above fees was (check one) [ ] Voluntary [ ] Required by the tax authority

9. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE . . . . . **$ 2,907**

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SCHEDULE 37 - PROPERTY TAX EXPENSES - RELATED PARTY

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

SECTION A - FOR ALL PROVIDERS **Expense**

1. 2018 real estate tax (due in 2019) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)
2. 2018 personal property tax (due in 2019) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.)

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

Date(s) paid _____ Amount(s) paid _____ Amount still outstanding _____

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2016 or 2017? ☐ Yes, explain below ☐ No

Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____

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

4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2018.
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule, section A, line 7.

Cost center name _____ Schedule number _____ Line number _____ Amount reported _____

6. The facility began to pay municipal service fees (check one) ☐ Prior to January 2018 ☐ On or after January 2018 Date began paying fees _____
7. Describe the services provided by the municipality for the above fees. _____
8. Payment of the above fees was (check one) ☐ Voluntary ☐ Required by the tax authority

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

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SCHEDULE 38 - NO LONGER USED

SCHEDULE 39 - OTHER NON-SALARY EXPENSES

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

	Nature and Source of Expense	Expense
1.		
2.		
3.		
4.	**TOTAL OTHER NON-SALARY EXPENSES (sum 1 - 3).**	**$ -**

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SCHEDULE 40 - ALLOCATION OF PROPERTY EXPENSES

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

				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)	$ 14,787					
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)	1,248					
8. Depreciation fixed equipment (s34)	-					
9. Depreciation moveable equip. (s34)	3,273					
10. Depreciation transportation veh. (s34)	-					
11. Depreciation other (s34)	-					
12. Expense on operating leases (s35)	112,554					
13. Expense on capitalized leases (s36)	-					
14. Property taxes or fees (s37)	2,907					
15. TOTAL EXPENSE (sum 1-14)	$ 134,769	$ -				
16. Less total directly assigned property exp.	$ -	(sum 15B, 15C 15D, 15E)				
17. NET UNASSIGNED/INDIRECT PROP.	**$ 134,769**	(15A less 16A)				
SECTION B - NON-SALARY EXPENSES	**A. Total From Sched.**	**B. NH Area**				
18. Square feet of service's building area	25,330	25,330				
19. Ratio to total square feet to 4 decimals	1.0000	1.0000				
20. Indirect property expense allocation	$ 134,769 (from 17A)	134,769 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	**$ 134,769** 17A + 20 A	**$ 134,769** 15B + 20B	**$ -** 15C + 20C	**$ -** 15D + 20D	**$ -** 15E + 20E	

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SCHEDULE 41 - ACCOUNTING AND REPORTING POLICIES

SECTION A - POLICIES AND PRACTICES

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

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

Type of Paid Time-Off	A. Based on Actual or Earned Time-Off?		B. Are Reported Amounts an Estimate?	
1. Vacation	[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	Location and Amount of Expense Included in This Cost Report: B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Expense	G. Expense Incurred by Related Party	H. Difference (G - F)
1.	Total related party lease expense					( )	XXXXXXXXX	XXXXXXXXX
2.	Insurance expense					XXXXXXXXX		XXXXXXXXX
3.	Amortization deferred expense					XXXXXXXXX		XXXXXXXXX
4.	Interest expense					XXXXXXXXX		XXXXXXXXX
5.	Depreciation expense					XXXXXXXXX		XXXXXXXXX
6.	Property tax expense					XXXXXXXXX		XXXXXXXXX
7.						XXXXXXXXX		XXXXXXXXX
8.						XXXXXXXXX		XXXXXXXXX
9.	SUBTOTAL FOR RELATED PARTY LEASES					($ -)	$ -	$ -

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10.						( )		$ -
11.						( )		-
12.						( )		-
13.						( )		-
14.						( )		-
15.	**TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)**							-

SECTION C - IDENTIFICATION OF RELATED PARTIES

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

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SCHEDULE 43 - IDENTIFICATION OF EXPENSES NOT RELATED TO PATIENT CARE

INSTRUCTIONS: To the extent possible, identify significant expenses included in this cost report which were not related to patient care. See Section 600 of the Cost Report Instructions for more details on such expenses. Attach additional sheets if necessary.

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

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SCHEDULE 43A - LEGAL FEES

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

	Description	Legal fees
1.	Prosecution or defense related to Medicare or Medicaid reimbursement	
2.	Prosecution or defense pertaining to compliance with licensure or certification requirements (see instructions above)	
3.	Defense of an owner or employee in a personal or criminal legal matter	
4.	Legal preparation resulting in the filing of an appeal under Chapters 50 or 227, Wisconsin Statutes, or a judicial suit	
5.	Collection of delinquent accounts	
6.	Corporate restructuring or reorganization	
7.	Potential purchase or sale of nursing home(s)	
8.	Purchase or sale of nursing home(s)	
9.	Negotiations with suppliers	
10.	Income taxes, payroll taxes, benefit plans	
11.	Union related activities	
12.	Guardianship for Medicaid residents	
13.	Other not related to patient care	10,857
14.		
15.		
16.	**TOTAL LEGAL FEES (should equal schedule 26, line 8).**	**$ 10,857**

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SCHEDULE 45 - DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL
Submit as a separate supporting document.

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

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SCHEDULE 46 - IDENTIFICATION OF EXPENSES FOR EMPLOYEE UNIQUE FRINGE BENEFITS

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

	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.									

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SCHEDULE 49 - PERCENTAGE OF OWNERSHIP

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

	Name of Individual or Entity	Percentage of Ownership
1.	JB Kenosha Healthcare LLC	100%
2.		
3.		
4.		
5.		

SCHEDULE 50 - INTEREST IN OTHER MEDICAID PROVIDERS

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

	Name and City of Medicaid Provider	Type of medical Services Provided	Nature and Extent of Interest in Provider
1.	The Bridges of Milwaukee	SNF	common ownership
2.	The Bridges of Appleton	SNF	common ownership
3.			
4.			
5.			

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SCHEDULE 51 - MEDICAL SUPPLY REVENUES FROM MEDICARE PART B

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

1. Does the nursing home bill Medicare for covered medical supplies under Medicaid Part B for Medicare eligible residents?..... [ ] Yes [X] No

2. Is the nursing home Medicare certified?..... [X] Yes [ ] No
   If yes, submit a copy of worksheet D from the most recent Medicare Cost Report.

3. Does the nursing home have a separate Medicare certification to bill for equipment and supplies?..... [ ] Yes [X] No

4. Medical supplies are billed to Medicare for the following types of residents (check all that apply) . . . . . [ ] Private Pay [ ] Title XIX (Medicaid) [ ] Other

5. What were the Medicare Part B revenues for medical suppllies? . . . . . _____

6. What were the costs related to the above medical supply revenues and where were they reported on this cost report?

   a. Expense _____ schedule _____ column _____ line _____

   b. Expense _____ schedule _____ column _____ line _____

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SCHEDULE 52 - MISCELLANEOUS MEDICAID NON-RATE REVENUES

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

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

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

Medicaid Revenue Item	Revenue Amount	Location in Cost Report: Schedule	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 (sum 1-7)	**$ -**		

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SCHEDULE 53 - INCENTIVES - PRIVATE ROOM & PROPERTY

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

Indicate if your facility is requesting a private room incentive

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

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

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

If your facility is requesting one of the incentives, you must complete the affidavit below and return it to the Department by July 1, 2018, to qualify for one of the private room incentives.

AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2019, to June 30, 2020, the _____ nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPRI) may be recouped retroactive to July 1, 2019, if the facility has charged Medicaid residents for private rooms during this period.

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

PROPERTY INCENTIVE:

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

ATTACH COPY OF INCENTIVE APPROVAL

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

If YES to either question above - Complete the Following:

Date Approval Received: _____

Has Construction Begun? [ ] YES [ ] NO If YES, when did it begin? _____

Has construction been completed [ ] YES [ ] NO If completed, when was it completed? _____

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

During this cost report period -

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

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

Numver of Medicaid Partnership Patient days in Replacement Facility or "Innovative Area"? _____