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	
Spring Valley Health and Rehabilitation Center	715-778-5545	kevinl@svhcs.org	
Facility Street Address	**City**	**State**	**Zip Code**
S830 Westland Drive	Spring Valley	WI	54767-8238

Contact Person	Contact Telephone Number	Contact Email Address
Kevin H. Larson, BSHCA, CNHA, FACHCA	715-778-5545 ext. 2003	kevinl@svhcs.org

Cost Report Period Start Date	Cost Report Period End Date	Medicaid Provider Number	National Provider Identifier (NPI)	POP ID Number
7/1/2019	6/30/2020	20152100	1548246929	826

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Kevin H. Larson, BSHCA, CNHA, FACHCA	Pamela J. Spence, Accounting Coord.	SVHCS, Inc. Business Office

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

Name and Title		Telephone Number	
Wipfli LLP		715-832-3407	
Address	**City**	**State**	**Zip Code**
4890 Owen Ayres Court, Suite 200	Eau Claire	WI	54701
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

SCHEDULE 2: Provider Notes

Vacation accrual is adjusted to cash basis. Utilities for the RCAC is reported on Schedule 27. The space previously used for Day Care is now used for nursing aide training. The interest and depreciation reported on Schedule 33R & 34R relate to the nursing home only.

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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 ownership (check one) [ ] (1) Proprietary [X] (2) Voluntary Non-Profit [ ] (3) Governmental

3. County of facility: Pierce — County Code: 47

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

5. Fiscal Year Beginning Month: Jul — Fiscal Year Ending Month: Jun

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	7/1/2019	50
Beds at End of Cost Reporting Period	6/30/2020	40
decrease # of beds	12/9/2019	(10)

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.	Spring Valley Health Care Services, Inc.	995	38	2	40
2.					-
3.					-
4.	TOTAL		38	2	40

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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: 20	☐	☐	☐	☐	☐	☐	x	☐
6. Room and Board - Other, Beds at end of cost report period:	☐	☐	☐	☐	☐	☐	☐	☐
7. Therapy services, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
8. Pharmacy	☐	☐	☐	☐	☐	☐	☐	☐
9. Laboratory or radiology services	☐	☐	☐	☐	☐	☐	☐	☐
10. Rental of building space	☐	☐	☐	☐	☐	☐	☐	☐
11. Adult Day Care	☐	☐	☐	☐	☐	☐	☐	☐
12. Home Health	☐	☐	☐	☐	☐	☐	☐	☐
13. Food catering services (meals on wheels, etc.)	☐	☐	☐	☐	☐	☐	☐	☐
14. Child care	☐	☐	☐	☐	☐	☐	☐	☐
15. Clinic	☐	☐	☐	☐	☐	☐	☐	☐
16. Other, Describe:	☐	☐	☐	☐	☐	☐	☐	☐
17. Any items checked in this column x = Yes blank = No	☐	☐	☐	☐	☐	☐	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)	2,361		2,361
1b.	ICF-IID Medicaid (T-19)		700	700
1c.	Family Care (T-19)	2,688		2,688
1d.	Other Medicaid Managed Care (T-19)			-
1e.	Hospice (T-19)	739		739
1f.	Ventilator (T-19)			-
2a.	Medicare (T-18)	790		790
2b.	Medicare Advantage, for days covered as a Part A stay	77		77
3a.	Private pay & Insurance	637		637
3b.	Medicare Advantage, for days not covered as a Part A stay	-		-
3c.	Hospice (Private pay & Insurance)	302		302
4.	Other, Specify:			
5.	TOTAL INHOUSE PATIENT DAYS	7,594	700	8,294

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**	**7,594**	**700**	**8,294**

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SCHEDULE 7 - NO LONGER USED

SCHEDULE 8: Medicaid Bedhold Eligibility

		Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	TOTAL
1.	MONTH													
2.	Days in Month	31	31	30	31	30	31	31	29	31	30	31	30	366
3.	Licensed Beds for Bed Hold Testing. . . .	50	50	50	50	50	50	40	40	40	40	40	40	540
4.	Occupancy Test:													
	Row 2 x (Row 3 x 94%)	1,457	1,457	1,410	1,457	1,410	1,457	1,166	1,090	1,166	1,128	1,166	1,128	15,492
5.	Inhouse patient days	715	719	715	658	664	683	644	631	762	712	707	684	8,294
6.	Bed Hold days	-	-	-	-	-	-	-	-	-	-	-	-	-
7.	**TOTAL DAYS . . .**	715	719	715	658	664	683	644	631	762	712	707	684	8,294
		n/a	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	

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

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

SCHEDULE 9 - NO LONGER USED

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SCHEDULE 10: Balance Sheet

ASSETS	Begin Date 7/1/19	End Date 6/30/20
CURRENT ASSETS		
Cash on hand and in bank	$242,154	$755,751
Temporary investments		
Resident accounts receivable	656,397	444,112
Other accounts receivable		14,410
Due from related parties		
Notes receivable		
Accrued interest receivable		
Inventories		
Prepaid expenses	15,946	23,574
Resident funds held in trust	4,064	540
Other current assets, list below:		
Board Designated - Cash & Investments	399	140,460
Under Loan Indenture - Cash	122,423	127,573
TOTAL CURRENT ASSETS	$1,041,383	$1,506,420
PROPERTY, PLANT, EQUIP.		
Land	$210,300	$79,800
Land improvements		
Buildings	9,436,270	2,675,295
Leasehold improvements		
Fixed equipment	133,806	-
Moveable equipment	806,602	123,919
Transportation equipment	43,572	43,572
Other		
Less: accumulated depreciation	(3,002,275)	(1,072,284)
TOTAL PROPERTY, PLANT, EQUIPMENT	$7,628,275	$1,850,302
OTHER		
Long term investments		
Other Assets, list below:		
Tax Credit Fee	4,417	1,411
TOTAL OTHER ASSETS	$4,417	$1,411
TOTAL ASSETS	$8,674,075	$3,358,133

LIABILITIES AND OWNERS' EQUITY	Begin Date 7/1/19	End Date 6/30/20
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Notes Payable to Bank	$-	$-
Due to related parties		
Accounts payable	590,873	153,226
Accrued salaries	67,231	82,149
Other accrued expenses	428,842	98,537
Resident trust funds payable	4,064	540
Other current liabilities	500	19,670
TOTAL CURRENT LIABILITIES	$1,091,510	$354,122
LONG TERM LIAB.		
Notes and loans payable (list) below:		
Long-Term Debt	3,772,451	2,186,991
Line of Credit Obligations	97,261	-
Tenant Security Deposits	8,500	9,000
Other long term liabilities		
TOTAL LONG TERM LIABILITIES	$3,878,212	$2,195,991
OWNER EQUITY		
OWNERS' EQUITY, list below:		
Net Assets	3,704,353	808,020
TOTAL OWNER'S EQUITY	$3,704,353	$808,020
TOTAL LIABILITIES AND EQUITY	$8,674,075	$3,358,133

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SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)			$3,704,353
2.	Add: Net income (from schedule 11, line 19)		$-	
	Owners' capital contribution			
	County appropriation			
	Net decrease in accrued vacation, holiday and sick time			
	Other, Specify:	Wage Adj $14,003/Depr Adj $9,793	23,796	
	Other, Specify:	Write-off Old Accounts Payable	461,551	
	Total additions			485,347
3.	Deduct: Net loss (from schedule 11, line 19)		($76,548)	
	Dividends and withdrawals		( )	
	Net increase in accrued vacation, holiday and sick time		( )	
	Other, Specify:	Loan Forgiveness$3,248,024/Village T	(3,299,592)	
	Other, Specify:	Mgmt fees $42,000 / Rel Party Adj -$3(	(5,540)	
	Total deductions			(3,381,680)
4.	**ENDING OWNERS' EQUITY (schedule 10).**			$808,020

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	$ 2,818,858
2.	Service fees	schedule 15, line 14A	225,050
3.	Rent from outside medical providers	schedule 15, line 14B	-
4.	Other	schedule 15, line 14C	-
5.	Dietary revenues	schedule 16, line 5A	1,574
6.	Miscellaneous services and materials revenue	schedule 16, line 16	1,394
7.	Rental revenues	schedule 17, line 22	-
8.	Revenues from other major activities	schedule 17, line 38	435,645
9.	Sales to related organizations	schedule 18, line 41	42,000
10.	Investment revenue	schedule 18, line 42	1,193
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	1,998
14.	Other revenue	schedule 18, line 50	407,422
15.	Subtract: deductions from revenues	schedule 14, line 5	(452,493)
16.	NET REVENUES		$ 3,482,641

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 37	$ (3,522,729)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	(36,460)
19.	**NET INCOME OR LOSS**		$ **(76,548)**

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	$1,317,109
2. Laboratory & Radiology	S21, L13a	10,365
3. Respiratory	S21, L13b	-
4. Pharmacy	S21, L13c	39,766
5. PT, OT and Speech	S22, L13a	100,697
6. Dental	S22, L13b	-
7. Physician	S22, L13c	2,700
8. Social Services	S23, L13a	66,067
9. Recreational Activities	S23, L13b	18,032
10. Religious Services	S23, L13c	-
11. Volunteer Coordinator	S24, L13a	-
12. Ward Clerks	S24, L13b	-
13. Psychotherapy	S24, L13c	1,625
14. Other	S24, L13d	3,600
15. Dietary	S25, L14a	266,711
16. Plant Operations and Maintenance	S25, L14b	104,298
17. Housekeeping	S25, L14c	78,843
18. Laundry and Linen	S25, L14d	-
19. Security	S25, L14e	-
20. Transportation	S25, L14f	$115
21. Administrative service expense	S26, L12	494,973
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L16a	
23. Beauty/Barber Shop	S27, L16b	
24. Child Care	S27, L16c	
25. Assisted Living	S27, L16d	365,943
26. 0	S27, L16e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	342,980
28. Heating fuel and utility expense	S29, L10	72,099
29. Interest on operating working capital loans	S30, L6	-
30. Insurance expense	S31, L9	31,019
31. Amortization expense	S32, L5	3,296
32. Interest on plant asset loans	S33, L15h	59,500
33. Depreciation expense	S34, L20c	123,093
34. Expense on operating and non-cap.leases	S35, L14	-
35. Expense on capitalized leases	S36A, L5	-
36. Property tax expense	S37, L7	19,898
37. TOTAL EXPENSES FOR REPORT PERIOD		$3,522,729

(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	$1,015,057	Dietary		S25, L1a	200,228
Laboratory & Radiology	S21, L1a	-	Plant operation / maintenance		S25, L1b	40,045
Respiratory	S21, L1b & 3b	-	Housekeeping		S25, L1c	53,269
Pharmacy	S21, L1c & 3c	-	Laundry and Linen		S25, L1d	-
PT, OT and Speech	S22, L1a &3a	-	Security		S25, L1e	-
Dental	S22, L1b &3b	-	Transportation		S25, L1f	-
Physician	S22, L1c &3c	-	Administrative service		S26, L5	167,373
Social Services	S23, L3a	35,954	Nurse aide training		S27, L1a	-
Recreational Activities	S23, L3b	8,223	Beauty and barber		S27, L1b	-
Religious Services	S23, L3c	-	Other, Specify:	Child Care	S27, L1c	-
Volunteer Coordinator	S24, L3a	-		Assisted Living	S27, L1d	232,989
Ward Clerks	S24, L3b	-		0	S27, L1e	-
Psychotherapy	S24, L1c & 3c	-	**TOTAL SALARY AND WAGE EXPENSE**			$1,753,138
Other	S24, L1d & 3d	-				

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SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$569,450
2. Medicaid Daily Rate (including bed hold)	1,967,443
3. Private Pay	271,550
4. Medical Supplies,Other	10,415
SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(452,493)
SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$2,366,365

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 $286.00
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				
3.	Pharmacy	56,079			
4.	Physical therapy	73,191			
5.	Speech/hearing therapy	8,826			
6.	Occupational therapy	86,954			
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	$225,050	$-	$-	

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 $168,971
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) $168,971

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	$14,284
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)	1,574		
4.	Meals On Wheels			
5.	Other Meals Sold			
5a.	**TOTAL DIETARY REVENUE**	**$1,574**		

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	90				
9.	Beauty and barber shops					
10.	Gift Shop					
11.	Canteen and snack counter					
12.	Vending machines	1,304				
13.	Sale of clothing					
14.	Television and cable service					
15.	Telephone and Internet					
16.	**TOTAL MISCELLANEOUS SERVICES AND MATERIALS**	**$1,394**				

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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. RCAC	435,645	
34.		
35.		
36.		
37.		
38. TOTAL REVENUE FROM OTHER MAJOR ACTIVITIES	**$435,645**	

SCHEDULE 18: Other Revenues

		Revenue
	SALES TO RELATED ORGANIZATIONS	
38.	Management fees Village of Spring Valley (rec'd $21,000 for July-Dec 2019 in FY21	$42,000
39.		
40.		
41.	TOTAL SALES TO RELATED ORGANIZATIONS	$42,000
42.	TOTAL INVESTMENT REVENUE	$1,193
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS	
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES	
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS	$1,998
	OTHER REVENUES	
46.	OBRA Level 1 Screen Rev $90; Mgmt fees $1,750	$1,840
47.	Provider Relief Fund $215,376; Reimb for Maintenance $25,029	240,405
48.	Miscellaneous	52,609
49.	WHEDA Grant	112,568
50.	TOTAL OTHER REVENUES	$407,422

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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	$498,648	$51,533	$464,876	$1,015,057
2. TOTAL SALARY AND WAGE HOURS	15,039 hrs.	2,498 hrs.	28,674 hrs.	$46,211
3. EXPENSE FOR PURCHASED SERVICES	$145,485	$19,998	$65,568	$231,051
AVERAGE WAGE PER HOUR	$33.16	$20.63	$16.21	$21.97
NURSING AND INCONTINENCY SUPPLIES				
4. Catheters, Incontinency Supplies (including purchased laundry service)				
OXYGEN				
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental				
OTHER				
6. Other medical supplies, personal comfort supplies and minor medical equipment				65,423
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)				5,578
8.				
9.				
10. TOTAL DAILY PATIENT SERVICE EXPENSE				**$1,317,109**

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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	$10,365		
7.	Expense for purchased service - Non billable	$-		$11,400
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Pharmacy - legend drugs Billable	$-	$-	28,366
9.	Pharmacy - over the counter drugs Billable	$-	$-	
10.	Supply and Other			
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES**	**$10,365**	**$-**	**$39,766**
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.			
2.	Number of hours worked - Billable.			
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	$100,697		
7.	Expense for purchased service - Non billable			$2,700
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	PT Supplies	-		
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	TOTAL EXPENSES	$100,697	$-	$2,700
14.	TOTAL HOURS	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	$35,954	$8,223	
4.	Number of hours worked - Non-billable	1,742 hrs.	757 hrs.	
5.	TOTAL SALARY AND WAGE EXPENSE	$35,954	$8,223	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$-	$-	$-
7.	Expense for purchased service - Non billable	$29,920		
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies	$193	$9,809	
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES . . . . . .**	**$66,067**	**$18,032**	**$-**
14.	**TOTAL HOURS . . . . . .**	**1,742 hrs.**	**757 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**	**QMRP**
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			$1,625	$3,600
SECTION C - SUPPLY AND OTHER EXPENSE					
8.					
9.					
10.					
11.					
12.					
SECTION D - TOTAL					
13.	**TOTAL EXPENSES**	$-	$-	$1,625	$3,600
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	$200,228	$40,045	$53,269	$-		
2. NUMBER OF HOURS WORKED	13,835 hrs.	2,119 hrs.	5,191 hrs.	hrs.		
SECTION B - DIETICIAN CONSULTANT						
3. Dietician consultant expense	$3,740	$-	$-	$-	$-	$-
SECTION C - OUTSIDE SERVICE						
4. Garbage Services		$3,770				
5. Contracted Services		26,870				
6.						
7.						
8. **TOTAL OUTSIDE SERVICE EXPENSES**	$-	$30,640	$-	$-	$-	$-
SECTION D - SUPPLY AND OTHER EXPENSE						
9. Supplies	$2,669	$21,987	$25,574	$-		$115
10. Food	60,074					
11. Repairs		11,626				
12.						
13.						
SECTION E - TOTAL						
14. TOTAL EXPENSES	**$266,711**	**$104,298**	**$78,843**	**$-**	**$-**	**$115**

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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)	$266,711
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)	$266,711

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other Guest Meals
6.	Meals served	29,628	28,501	1,006			121
7.	Ratio to total meals served to 4 decimals	1.0000	0.9620	0.0340			0.0041
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$266,711 From line 5	$256,576 8A x 7B	$9,068 8A x 7C	$- 8A x 7D	$- 8A x 7E	$1,094 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)	1,574
11.	NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C - line 10C)	$7,494

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	48,815	48,815				
13.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000				
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$104,298 From S25, L18	$104,298 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	48,815	48,815			
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$78,843	$78,843	$-	$-	$-
		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	8,294	8,294			
19.	Ratio to total pounds to 4 decimals	1.0000	1.0000			
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.		$-	$-	$-	$-
		From S25, L18	20A x 19B	20A x 19C	20A x 19D	20A x 19E

SECTION C - ALLOCATION OF SECURITY EXPENSES

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

SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES

		A. Total	B. Nursing Home Area	Non-Nursing Home Areas Receiving Transportation Services		
24.	Alloc. Basis, Specify: Usage of Services	100	100			
25.	Ratio to total alloc. basis to 4 decimals	1.0000	1.0000			
26.	TOTAL TRANS. EXPENSE ALLOC.	$115	$115	$-	$-	$-
		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	$145,705
2.	Medical Records	21,668
3.	Central Supply	-
4.	Scheduling	
5.	Total Salary and Wage Expense	$167,373
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	$10,825
9.	Licensed bed assessment	96,050
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	220,725
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	$494,973

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Telephone	$25,875
2.	Postage	974
3.	Supplies	84,308
4.	Travel	1,031
5.	Education	6,966
6.	cable television	15,935
7.	Accounting	46,049
8.	Dues & Subscriptions	8,281
9.	Advertising	4,377
10.	Fines & Penalties	825
11.	Contract Services	25,567
12.	Interest paid on Visa (included in #8200-550-01)	537
13.		
14.		
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .**	**$220,725**

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) $494,973

SECTION A - DIRECT EXPENSES

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	RCAC	Non-Nursing Home Areas Receiving Administrative Services	
2. Telephone	$(25,875)	$25,875			
3. Education	(6,966)	6,966			
4. Dues & Subscriptions	(8,281)	8,281			
5. Travel	(1,031)	1,031			
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.	$(42,153)	$42,153			
16. NET UNASSIGNED EXPENSE	$452,820				

SECTION B - ALLOC. OF INDIRECT EXP.

	A. Total	B. NH Provider	RCAC		
17. Allocation basis amounts	2,802,010	2,366,365	435,645		
18. Ratio to total basis to 4 decimals	1.0000	0.8445	0.1555		
19. UNASSIGNED ADMIN. EXP. ALLOC	$452,820	382,406	70,414	-	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE	$494,973	$424,559	$70,414	$-	$-
	(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**	**Child Care**	**Assisted Living**	
1. TOTAL SALARY AND WAGE EXPENSE	$-			$232,989	
2. NUMBER OF HOURS WORKED	hrs.			15,391 hrs.	

SECTION B - NON-SALARY EXPENSES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**Child Care**	**Assisted Living**	**-**
3. Supplies				$8,348	
4. Repairs				52,348	
5. Contracted Services				900	
6. Food				23,522	
7. Telephone				2,548	
8. Postage/Advertising/Misc				379	
9. Licenses / Dues / Management Fees				20,796	
10. Education				230	
11. Gas / Electricity / Water				23,883	
12.					
13.					
14.					
15. **TOTAL NON-SALARY EXPENSES**	$-	$-	$-	$132,954	$-

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	**Child Care**	**Assisted Living**	**-**
16. TOTAL EXPENSES				**$365,943**	

SCHEDULE 28: Fringe Benefits

Fringe Benefits Paid on Behalf of Employees		Self-Funded?		Expense
1.	Employer's share of F.I.C.A.			$128,127
2.	State unemployment compensation			298
3.	Federal unemployemnt compensation			
4.	Worker's compensation insurance	☐ Yes	☒ No	18,702
5.	Health, Dental & Vision Insurance	☒ Yes	☐ No	181,589
6.	Life and disability insurance	☐ Yes	☒ No	8,564
7.	Wage continuation insurance	☐ Yes	☐ No	
8.	Pension and deferred comp. plans (section C)	☐ Yes	☐ No	
9.	Post-Employment Physicals and Vaccines			1,683
10.	Uniforms			
11.	Other Employee Benefits			4,017
12.				
13.				
14.				
15.	TOTAL PAID ON BEHALF OF EMPLOYEES			$342,980
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**	**$342,980**

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SCHEDULE 28B: Fringe Benefits - Self-Funded

	Type of Self-Funded Expenses	Worker's Compensation Insurance	Health, Dental and Vision Insurance	Life and Disability Insurance	Wage Continuation Insurance	Pension and Deferred Compensation Plans
	Checked as self-funded on Sch 28?		x			
1	Actual Claims Paid		$181,589			
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)	$-	$181,589	$-	$-	$-

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SCHEDULE 29: Heating and Utility Service Expenses

SECTION A - ACCRUED EXPENSE BY TYPE

	Expense by Type	Accrued Expense
1.	Fuel oil	
2.	Natural gas	15,917
3.	L.P. gas	
4.	Coal	
5.	Electricity	44,521
6.	Water and sewer utility charges	11,661
7.	Purchased steam	
8.		
9.		
10.	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$72,099**

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	38,828	38,828				
12.	Ratio to total square feet to 4 decimals	1.0000	1.0000				
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**72,099**	**$72,099**	**$-**	**$-**	**$-**	**$-**
		From line 10	13A x 12B	13A x 12C	13A x 12D	13A x 12E	13A x 12F

SCHEDULE 30: Working Capital Loans

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

SCHEDULE 31: Accrued Insurance Expenses

	A. Type of Insurance Coverage		B. Self-Funded?	C. Insurance Expense
1.	Property insurance on building and contents		☐ Yes ☒ No	$2,778
2.	Automobile insurance		☐ Yes ☒ No	2,094
3.	Liability insurance		☐ Yes ☒ No	8,676
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	Valley Villas	☐ Yes ☒ No	10,803
8.	Other General	Crime $208, Surety $324, D&O $6,136	☐ Yes ☒ No	6,668
9.	**TOTAL INSURANCE EXPENSE**			**$31,019**

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.	USDA Financing Fees - SNF	2	$63,385	30	$47,275	$-	$176
2.	RCAC Financing Fees	4	58,300	30	40,779	38,814	1,965
3.	WHEDA Tax Credit (RCAC)	6	31,217	30	21,925	20,884	1,041
4.	USDA Financing Fees - Day Ca	3	20,453	15	11,249	-	114
5.	**TOTAL AMORTIZATION EXPENSE**						**$3,296**

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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 7/1/2019 Begin Bal.	E. 6Mo.date 12/31/2019 6 Mo. Bal.	F. End date 6/30/2020 End Bal.	G. Interest Rate	H. Interest Expense
1. Name: Royal Credit Union Related party? [ ] Yes [X] No Purpose: SNF Construction	Nov-11	Nov-41	$6,023,044	$1,234,786	$-	$-	4.20%	$-
2. Name: USDA Rural Development Related party? [ ] Yes [X] No Purpose: Nursing Home Equipment	Nov-11	Nov-16	$510,000	$340,139	$-	$-	3.75%	$-
3. Name: USDA Rural Development Related party? [ ] Yes [X] No Purpose: Child Care Construction	Sep-09	Sep-27	$595,000	$423,595	$-	$-	3.38%	$-
4. Name: Bremer Bank Related party? [ ] Yes [X] No Purpose: RCAC Construction	Dec-09	Jun-29	$860,690	$755,726	$746,096	$736,144	6.50%	$49,173
5. Name: West Cap Related party? [ ] Yes [X] No Purpose: RCAC Construction	Feb-09	Apr-40	$415,800	$347,899	$347,899	$335,364	0.00%	$10,327
6. Name: WHEDA Tax Exchange Related party? [ ] Yes [X] No Purpose: RCAC Construction	Aug-10	Jun-26	$1,687,672	$787,131	$730,847	$674,563	0.00%	$-
7. Name: Related party? [ ] Yes [ ] No Purpose:								
15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2)				$3,889,276	$1,824,842	$1,746,071		$59,500

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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 7/1/2019 Begin Bal.	E. 6Mo.date 12/31/2019 6 Mo. Bal.	F. End date 6/30/2020 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 7/1/2019 Begin Bal.	E. 6Mo.date 12/31/2019 6 Mo. Bal.	F. End date 6/30/2020 End Bal.	G. Interest Rate	H. Interest Expense
1. Name Bremer Bank? Related party? [ ] Yes [X] No Purpose purchase NH building	Jul-19	Jul-29	$1,300,000	$-	$1,300,000	$1,300,000	3.69%	$50,073
2. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
3. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
4. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
5. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
6. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
7. Name ____ Related party? [ ] Yes [ ] No Purpose ____								
15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).				$-	$1,300,000	$1,300,000		$50,073

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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 7/1/2019 Begin Bal.	E. 6Mo.date 12/31/2019 6 Mo. Bal.	F. End date 6/30/2020 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 / B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date / E. Ending Balance
	7/1/2019			6/30/2020
1. Land	210,300		(130,500)	$79,800
2. Land Improvements	92,358		( )	92,358
3. Buildings	9,343,912		(6,760,975)	2,582,937
4. Leasehold Improvements			( )	-
5. Fixed equipment	133,806		(133,806)	-
6. Moveable equipment	806,602		(682,683)	123,919
7. Transportation vehicles	43,572		( )	43,572
8.			( )	-
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$10,630,550	$-	($7,707,964)	$2,922,586

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
		7/1/2019			6/30/2020
11. Land Improvements		$86,206	$4,460	( )	$90,666
12. Buildings	SL - Various	2,249,018	101,344	(1,506,589)	843,773
13. Leasehold Improvements				( )	-
14. Fixed equipment	SL - Various	43,589	268	(43,857)	-
15. Moveable equipment	SL - Various	600,651	10,796	(502,509)	108,938
16. Transportation vehicles	SL - Various	22,812	6,225	( )	29,037
17.				( )	-
18.				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$3,002,276		($2,052,955)	$1,072,414
20. TOTAL DEPRECIATION EXPENSE			**$123,093**		

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

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SCHEDULE 34RP: Related Party Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date 7/1/2019 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date 6/30/2020 E. Ending Balance
1. Land		$17,678	( )	$17,678
2. Land Improvements			( )	-
3. Buildings	-	922,818	( )	922,818
4. Leasehold Improvements			( )	-
5. Fixed equipment			( )	-
6. Moveable equipment	-	30,282	( )	30,282
7. Transportation vehicles			( )	-
8.			( )	-
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$-	$970,778	($-)	$970,778

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date 7/1/2019 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 6/30/2020 E. Ending Balance
11. Land Improvements				( )	$-
12. Buildings		-	26,367	( )	26,367
13. Leasehold Improvements				( )	-
14. Fixed equipment				( )	-
15. Moveable equipment		-	2,020	( )	2,020
16. Transportation vehicles				( )	-
17.				( )	-
18.				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$-		($-)	$28,387
20. TOTAL DEPRECIATION EXPENSE			**$28,387**		

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.		☐ Yes ☐ No	☐ Yes ☐ No				
2.		☐ Yes ☐ No	☐ Yes ☐ No				
3.		☐ Yes ☐ No	☐ Yes ☐ No				

SECTION B - LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES

	A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (If known)	E. Lease Inception Date (MM/YY)	F. Describe Property	G. Lease Exp.
4.		☐ Yes ☐ No	☐ Yes ☐ No				
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 **$-**

SCHEDULE 36A: Capitalized Leases

SECTION A - CAPITALIZED LEASE INFORMATION

Lease Expense

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

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

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

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

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

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

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

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

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

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SCHEDULE 36B: Capitalized Leases

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

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

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

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

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

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

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

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

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

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

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SCHEDULE 37: Property Taxes

SECTION A - FOR ALL PROVIDERS **Expense**

1. 2020 Real Estate Tax Bill
2. 2020 Personal Property Tax Bill

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

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

3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2018 or 2019? ☐ Yes, explain below ☐ No

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

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

4. 2020 Municipal Service Fee or Payment in Lieu of Taxes $19,898
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule.

Cost center name Property taxes Schedule number 37 Line number 1 Amount reported $13,898

6. Describe the services provided by the municipality for the above fees. fire, police, etc (not sure how to reflect above without doubling expense

7. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE **$19,898**

Medicaid PopID & Provider Number 826-20152100

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

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SCHEDULE 40: Allocated Property Expenses

SECTION A - DIRECT PROPERTY EXP.	A. Total From Sched.	B. NH Service Area	Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities C. RCAC	D.	E.
1. Property insurance (s31)	$2,778	$2,778			
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	3,296		3,296		
4. Plant asset interest expense (s33)	59,500		59,500		
5. Depreciation land improvements (s34)	4,460		4,460		
6. Depreciation buildings (s34)	101,344	16,111	85,233		
7. Depreciation leasehold improve. (s34)	-				
8. Depreciation fixed equipment (s34)	268	268			
9. Depreciation moveable equip. (s34)	10,796	2,916	7,880		
10. Depreciation transportation veh. (s34)	6,225	6,225			
11. Depreciation other (s34)	-				
12. Expense on operating leases (s35)	-				
13. Expense on capitalized leases (s36)	-				
14. Property taxes or fees (s37)	19,898	19,898			
15. TOTAL EXPENSE	$208,565	$48,196	$160,369		
16. Less total directly assigned property exp.	$208,565				
17. NET UNASSIGNED/INDIRECT PROP.	**$-**				

SECTION B - NON-SALARY EXPENSES	A. Total From Sched.	B. NH Area	RCAC		
18. Square feet of service's building area	43,008	43,008			
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	RCAC		
21. TOTAL PROP. EXP. FOR EACH AREA	**$208,565** 17A + 20 A	**$48,196** 15B + 20B	**$160,369** 15C + 20C	**$-** 15D + 20D	**$-** 15E + 20E

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SCHEDULE 41: Paid Time-Off Expenses

SECTION A - POLICIES AND PRACTICES

1. Accounting method - expenses are to be reported on the accrual method of accounting except for governmental facilities, which may use the cash method. Check the accounting method used in this cost report. [X] Accrual [ ] Cash

2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.
Items with purchase price of $1,000 or more and a useful life greater than 1 year.

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

4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.
Spring Valley Health Care Services, Inc. follows generally accepted accounting principles.

SECTION B - NON-PRODUCTIVE SALARY EXPENSE AND HOURS

Type of Paid Time-Off	A. Based on Actual or Earned Time-Off?		B. Are Reported Amounts an Estimate?	
1. Vacation	[X] Actual	[ ] Earned	[ ] Yes	[X] No
2. Holidays	[X] Actual	[ ] Earned	[ ] Yes	[X] No
3. Sick time	[X] Actual	[ ] Earned	[ ] Yes	[X] No
4. Break, meal time	[X] Actual	[ ] Earned	[ ] Yes	[X] No
5. Holiday premium	[X] Actual	[ ] Earned	[ ] Yes	[X] No
6. In-service training	[X] Actual	[ ] Earned	[ ] Yes	[X] No
7. _____	[ ] Actual	[ ] Earned	[ ] Yes	[ ] No

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

SECTION A - RELATED PARTY LEASES

	A. Description of Expense Item	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	Loans	33P	H	15	50,073
5.	Depreciation expense	Depreciation	34P	C	20	28,387
6.	Property tax expense					
7.						
8.						
9.	SUBTOTAL FOR RELATED PARTY LEASES					$78,460

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10.						
11.	Management fees	Other Income	18	1	35	(42,000)
12.						
13.						
14.						
15.	**TOTAL AMOUNT TO ADJUST RELATED PARTY TRANSACTIONS TO COST (to schedule 11, line 18)**					$36,460

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.

Village of Spring Valley, Spring Valley, Wisconsin

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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	$4,377	Admin	26-ATT	E	8
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	825	Admin	26-ATT	E	9
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.

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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.	Spring Valley Health Care, Inc.	100%
2.		
3.		
4.		
5.		

SCHEDULE 50: Interest in Other Providers

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

SCHEDULE 51 - NO LONGER USED

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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	**$-**		

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 Spring Valley Health and Rehabilitation 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? [x] YES

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