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	
Saint John's Communities, Inc.	414-272-2022	info@stjm.org	
Facility Street Address	**City**	**State**	**Zip Code**
1840 N. Prospect Avenue	Milwaukee	WI	53202

Contact Person	Contact Telephone Number	Contact Email Address
Beth Fields	414-831-6993	bfields@saintjohnsmilw.org

Cost Report Period Start Date	Cost Report Period End Date	Medicaid Provider Number	National Provider Identifier (NPI)	POP ID Number
1/1/2020	12/31/2020	20129300	1295866325	839

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Mary Milliren	Dan Lemminger	1840 N. Prospect Avenue, Milwaukee, WI

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

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

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

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

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

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

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

Medicaid PopID & Provider Number 839-20129300

SCHEDULE 2: Provider Notes

Medicaid PopID & Provider Number 839-20129300

SCHEDULE 3: General Information

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

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

3. County of facility: Milwaukee — County Code: 40

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

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

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

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

	DATE	BEDS
Beds at Beginning of Cost Reporting Period	1/1/2020	50
Beds at End of Cost Reporting Period	12/31/2020	30
New SNF, delicensed 20 beds	2/1/2020	(20)

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

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

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

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

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

	A. NAME	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1.	Saint John's Communities, Inc.	2611	20	10	30
2.					-
3.					-
4.	TOTAL		20	10	30

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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:	60			x	x	x	x	x	x
5. Apartment units, Beds at end of cost report period:	295			x	x	x		x	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	x	x	x	x	x

SCHEDULE 5 - NO LONGER USED

SCHEDULE 6: Total Patient Days

SECTION A - INHOUSE PATIENT DAYS

		LEVEL OF CARE (LOC) NON DD	DD	TOTAL
1a.	Medicaid (T-19)	15		15
1b.	ICF-IID Medicaid (T-19)			-
1c.	Family Care (T-19)			-
1d.	Other Medicaid Managed Care (T-19)			-
1e.	Hospice (T-19)	108		108
1f.	Ventilator (T-19)			-
2a.	Medicare (T-18)	854		854
2b.	Medicare Advantage, for days covered as a Part A stay			-
3a.	Private pay & Insurance	4,978		4,978
3b.	Medicare Advantage, for days not covered as a Part A stay			-
3c.	Hospice (Private pay & Insurance)			-
4.	Other, Specify:			
5.	TOTAL INHOUSE PATIENT DAYS	5,955	-	5,955

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	65		65
8.	TOTAL CHARGED BED HOLD DAYS	65	-	65

SECTION C - TOTAL PATIENT DAYS

		NON DD	DD	TOTAL
9.	**TOTAL DAYS**	**6,020**	**-**	**6,020**

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SCHEDULE 7 - NO LONGER USED

SCHEDULE 8: Medicaid Bedhold Eligibility

		Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	**TOTAL**
1.	MONTH													
2.	Days in Month	31	29	31	30	31	30	31	31	30	31	30	31	366
3.	Licensed Beds for Bed Hold Testing. . . .	50	30	30	30	30	30	30	30	30	30	30	30	380
4.	Occupancy Test:													
	Row 2 x (Row 3 x 94%)	1,457	818	874	846	874	846	874	874	846	874	846	874	10,903
5.	Inhouse patient days	864	611	604	498	459	438	483	448	430	397	369	354	5,955
6.	Bed Hold days	5	5	5	5	5	5	5	6	6	6	6	6	65
7.	**TOTAL DAYS . . .**	869	616	609	503	464	443	488	454	436	403	375	360	6,020
		n/a	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	

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

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

SCHEDULE 9 - NO LONGER USED

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SCHEDULE 10: Balance Sheet

ASSETS	Begin Date 1/1/20	End Date 12/31/20
CURRENT ASSETS		
Cash on hand and in bank	$996,858	$2,112,782
Temporary investments		
Resident accounts receivable	677,313	85,163
Other accounts receivable		
Due from related parties	14,215,217	
Notes receivable		
Accrued interest receivable		
Inventories	100,036	121,708
Prepaid expenses	117,557	186,350
Resident funds held in trust	356	283
Other current assets, list below:		
TOTAL CURRENT ASSETS	$16,107,337	$2,506,286
PROPERTY, PLANT, EQUIP.		
Land	$156,788	$156,788
Land improvements	54,023	54,023
Buildings	10,386,287	12,953,416
Leasehold improvements		
Fixed equipment		
Moveable equipment	2,759,052	2,585,742
Transportation equipment	55,028	55,028
Other	-	
Less: accumulated depreciation	(12,914,330)	(6,241,751)
TOTAL PROPERTY, PLANT, EQUIPMENT	$496,848	$9,563,246
OTHER		
Long term investments		
Other Assets, list below:		
Deferred Financing Fees	299,539	190,054
Capitalized Interest	60,308	332,438
TOTAL OTHER ASSETS	$359,847	$522,492
TOTAL ASSETS	$16,964,032	$12,592,024

LIABILITIES AND OWNERS' EQUITY	Begin Date 1/1/20	End Date 12/31/20
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Due to related parties		11,092,656
Accounts payable	35,646	254,494
Accrued salaries	240,744	136,949
Other accrued expenses	154,864	119,036
Resident trust funds payable	356	283
Other current liabilities		
TOTAL CURRENT LIABILITIES	$431,610	$11,603,418
LONG TERM LIAB.		
Notes and loans payable (list) below:		
WHEFA Bonds	23,872,792	9,742,503
Other long term liabilities		
TOTAL LONG TERM LIABILITIES	$23,872,792	$9,742,503
OWNER EQUITY		
OWNERS' EQUITY, list below:		
Retained Earnings	(7,340,370)	(8,753,897)
TOTAL OWNER'S EQUITY	$(7,340,370)	$(8,753,897)
TOTAL LIABILITIES AND EQUITY	$16,964,032	$12,592,024

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SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)		$(7,340,370)
2. Add	Net income (from schedule 11, line 19)	$-	
	Owners' capital contribution		
	County appropriation		
	Net decrease in accrued vacation, holiday and sick time		
	Other, Specify: _____		
	Other, Specify: _____		
	Total additions		-
3. Deduct	Net loss (from schedule 11, line 19)	($1,413,527)	
	Dividends and withdrawals	( )	
	Net increase in accrued vacation, holiday and sick time	( )	
	Other, Specify: _____	( )	
	Other, Specify: _____	( )	
	Total deductions		(1,413,527)
4.	**ENDING OWNERS' EQUITY (schedule 10).**		$(8,753,897)

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	$ 2,844,034
2.	Service fees	schedule 15, line 14A	422,649
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	64,212
7.	Rental revenues	schedule 17, line 22	-
8.	Revenues from other major activities	schedule 17, line 38	-
9.	Sales to related organizations	schedule 18, line 41	-
10.	Investment revenue	schedule 18, line 42	-
11.	Gains (Losses) on disposal of assets	schedule 18, line 43	-
12.	Grants for government-subsidized employees	schedule 18, line 44	-
13.	Grants, contributions, donations	schedule 18, line 45	-
14.	Other revenue	schedule 18, line 50	476,294
15.	Subtract: deductions from revenues	schedule 14, line 5	(391,152)
16.	NET REVENUES		$ 3,416,037

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 37	$ (4,829,564)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	-
19.	**NET INCOME OR LOSS**		$ **(1,413,527)**

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SCHEDULE 12: Summary of Total Expenses

All values are automatically posted from other schedules.

Cost Center	Reference	Expense
1. Daily patient service expense	S20, L10	$1,465,619
2. Laboratory & Radiology	S21, L13a	6,631
3. Respiratory	S21, L13b	-
4. Pharmacy	S21, L13c	28,673
5. PT, OT and Speech	S22, L13a	180,157
6. Dental	S22, L13b	-
7. Physician	S22, L13c	24,000
8. Social Services	S23, L13a	32,920
9. Recreational Activities	S23, L13b	91,235
10. Religious Services	S23, L13c	19,812
11. Volunteer Coordinator	S24, L13a	-
12. Ward Clerks	S24, L13b	45,836
13. Psychotherapy	S24, L13c	2,400
14. Other	S24, L13d	
15. Dietary	S25, L14a	480,964
16. Plant Operations and Maintenance	S25, L14b	99,512
17. Housekeeping	S25, L14c	228,564
18. Laundry and Linen	S25, L14d	3,514
19. Security	S25, L14e	-

Cost Center	Reference	Expense
20. Transportation	S25, L14f	$-
21. Administrative service expense	S26, L12	829,039
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L16a	34,665
23. Beauty/Barber Shop	S27, L16b	63,754
24. 0	S27, L16c	
25. 0	S27, L16d	
26. 0	S27, L16e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	509,649
28. Heating fuel and utility expense	S29, L10	17,921
29. Interest on operating working capital loans	S30, L6	-
30. Insurance expense	S31, L9	62,381
31. Amortization expense	S32, L5	9,965
32. Interest on plant asset loans	S33, L15h	370,423
33. Depreciation expense	S34, L20c	220,150
34. Expense on operating and non-cap.leases	S35, L14	1,780
35. Expense on capitalized leases	S36A, L5	-
36. Property tax expense	S37, L7	-
37. TOTAL EXPENSES FOR REPORT PERIOD		$4,829,564

(To schedule 11, line 17)

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SCHEDULE 13: Summary of Salary & Wage Expenses

All values are automatically posted from other schedules.

Cost Center and Schedule		Total Salary and Wage Expense
Daily patient service	S20, L1d	$1,177,329
Laboratory & Radiology	S21, L1a	-
Respiratory	S21, L1b & 3b	-
Pharmacy	S21, L1c & 3c	-
PT, OT and Speech	S22, L1a &3a	-
Dental	S22, L1b &3b	-
Physician	S22, L1c &3c	-
Social Services	S23, L3a	32,920
Recreational Activities	S23, L3b	77,002
Religious Services	S23, L3c	19,812
Volunteer Coordinator	S24, L3a	-
Ward Clerks	S24, L3b	45,836
Psychotherapy	S24, L1c & 3c	-
Other	S24, L1d & 3d	-

Cost Center and Schedule			Total Salary and Wage Expense
Dietary		S25, L1a	325,568
Plant operation / maintenance		S25, L1b	79,700
Housekeeping		S25, L1c	121,294
Laundry and Linen		S25, L1d	160
Security		S25, L1e	-
Transportation		S25, L1f	-
Administrative service		S26, L5	128,004
Nurse aide training		S27, L1a	34,665
Beauty and barber		S27, L1b	59,038
Other, Specify:	0	S27, L1c	-
	0	S27, L1d	-
	0	S27, L1e	-
TOTAL SALARY AND WAGE EXPENSE			$2,101,328

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SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$375,470
2. Medicaid Daily Rate (including bed hold)	78,517
3. Private Pay	2,353,109
4. Medical Supplies,Other	36,938
SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(391,152)
SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$2,452,882

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 $472.70
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	$3,154			
2.	Radiology	2,693			
3.	Pharmacy	27,524			
4.	Physical therapy	227,187			
5.	Speech/hearing therapy	11,862			
6.	Occupational therapy	146,937			
7.	Physician care				
8.	Psychotherapy				
9.	Respiratory therapy				
10.	Social services				
11.	Recreational activities				
12.	Special duty nursing	3,292			
13.	Other, Specify:				
14.	TOTAL SPECIAL SERVICE REVENUE	$422,649	$-	$-	

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: $385,986
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): $385,986

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?	[X] Yes	[ ] No	If yes, amount of revenue	$78,407
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	$152,893
21.	Did you charge rent to a rehabilitation agency or independent contractor?	[ ] Yes	[X] No	If yes, amount of revenue	

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SCHEDULE 16: Other Revenues

SECTION A - CAFETERIA AND DIETARY REVENUE

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

SECTION B - MISCELLANEOUS SERVICES AND MATERIALS

			Expenses Directly Ascribable To Or Identifiable With Revenue			
		Revenue	A. Related Direct Expense (if known)	B. Cost Center where expense included	C. Schedule Number	D. Line Number
6.	Laundry					
7.	Sale of personal hygiene items					
8.	Transportation					
9.	Beauty and barber shops	64,212				
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**	**$64,212**				

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SCHEDULE 17: Other Revenues

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

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

SCHEDULE 18: Other Revenues

		Revenue
	SALES TO RELATED ORGANIZATIONS	
38.		
39.		
40.		
41.	TOTAL SALES TO RELATED ORGANIZATIONS	$-
42.	TOTAL INVESTMENT REVENUE	
43.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS	
44.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES	
45.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS	
	OTHER REVENUES	
46.	Miscellaneous	$473,474
47.	OBRA Level I Screening	2,820
48.		
49.		
50.	TOTAL OTHER REVENUES	$476,294

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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	$544,814	$189,712	$442,803	$1,177,329
2. TOTAL SALARY AND WAGE HOURS	12,189 hrs.	6,311 hrs.	21,998 hrs.	$40,498
3. EXPENSE FOR PURCHASED SERVICES	$32,384	$48,667	$62,431	$143,482
AVERAGE WAGE PER HOUR	$44.70	$30.06	$20.13	$29.07

NURSING AND INCONTINENCY SUPPLIES		
4. Catheters, Incontinency Supplies (including purchased laundry service)		$25,296
OXYGEN		
5. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental		14,469
OTHER		
6. Other medical supplies, personal comfort supplies and minor medical equipment		103,485
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)		1,558
8.		
9.		
10. TOTAL DAILY PATIENT SERVICE EXPENSE		**$1,465,619**

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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	$6,631		
7. Expense for purchased service - Non billable	$-		$3,432
SECTION C - SUPPLY AND OTHER EXPENSE			
8. Pharmacy - legend drugs Billable	$-	$-	25,231
9. Pharmacy - over the counter drugs Billable	$-	$-	10
10. Supply and Other			
11.			
12.			
SECTION D - TOTAL			
13. TOTAL EXPENSES	**$6,631**	**$-**	**$28,673**
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	$180,157		
7.	Expense for purchased service - Non billable			$24,000
SECTION C - SUPPLY AND OTHER EXPENSE				
8.				
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	TOTAL EXPENSES	$180,157	$-	$24,000
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	$32,920	$77,002	$19,812
4.	Number of hours worked - Non-billable	1,082 hrs.	3,202 hrs.	424 hrs.
5.	TOTAL SALARY AND WAGE EXPENSE	$32,920	$77,002	$19,812
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$-	$-	$-
7.	Expense for purchased service - Non billable			
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Programs		$8,835	
9.	Supplies		2,573	
10.	Professional Seminars		894	
11.	Miscellaneous		1,931	
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES**	**$32,920**	**$91,235**	**$19,812**
14.	**TOTAL HOURS**	**1,082 hrs.**	**3,202 hrs.**	**424 hrs.**

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SCHEDULE 24: Special Service Expenses

		TYPE OF SERVICE			
SECTION A - SALARY AND WAGES		**A. Volunteer Coord.**	**B. Ward Clerks**	**C. Psychotherapy**	
1.	Expense for hours worked - Billable	$-	$-		
2.	Number of hours worked - Billable	hrs.	hrs.		
3.	Expense for hours worked - Non-billable		$45,836		
4.	Number of hours worked - Non-billable		2,044 hrs.		
5.	TOTAL SALARY AND WAGE EXPENSE	$-	$45,836	$-	$-
SECTION B - PURCHASED SERVICES					
6.	Expense for purchased service - Billable				
7.	Expense for purchased service - Non billable			$2,400	
SECTION C - SUPPLY AND OTHER EXPENSE					
8.					
9.					
10.					
11.					
12.					
SECTION D - TOTAL					
13.	**TOTAL EXPENSES**	$-	$45,836	$2,400	
14.	**TOTAL HOURS**	hrs.	2,044 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	$325,568	$79,700	$121,294	$160		
2.	NUMBER OF HOURS WORKED	16,899 hrs.	2,818 hrs.	6,660 hrs.	9 hrs.		
	SECTION B - DIETICIAN CONSULTANT						
3.	Dietician consultant expense	$3,150	$-	$-	$-	$-	$-
	SECTION C - OUTSIDE SERVICE						
4.	Linen Service	$10,345					
5.	Contracted Services	1,434	13,869	80,855			
6.							
7.							
8.	**TOTAL OUTSIDE SERVICE EXPENSES**	$11,779	$13,869	$80,855	$-	$-	$-
	SECTION D - SUPPLY AND OTHER EXPENSE						
9.	Food	$100,927					
10.	Supplies	17,923	335	24,871	2,446		
11.	Repair/Replace	18,856	5,608	1,544			
12.	Linen				908		
13.	Miscellaneous	2,761					
	SECTION E - TOTAL						
14.	**TOTAL EXPENSES**	**$480,964**	**$99,512**	**$228,564**	**$3,514**	**$-**	**$-**

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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)	$480,964
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)	$480,964

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other
6.	Meals served	17,865	17,865				
7.	Ratio to total meals served to 4 decimals	1.0000	1.0000				
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$480,964 From line 5	$480,964 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	30,272	30,272				
13.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000				
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$99,512 From S25, L18	$99,512 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	30,272	30,272			
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$228,564	$228,564	$-	$-	$-
		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	59,561	59,561			
19.	Ratio to total pounds to 4 decimals	1.0000	1.0000			
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.	$3,514	$3,514	$-	$-	$-
		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	30,272	30,272			
22.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000			
23.	TOTAL SECURITY EXPENSE ALLOC.		$-	$-	$-	$-
		From S25, L18	23A x 22B	23A x 22C	23A x 22D	23A x 22E

SECTION D - ALLOCATION OF TRANSPORTATION EXPENSES

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

SCHEDULE 26: Administrative Service Expenses

		Expenses
SECTION A - SALARY AND WAGES		
1.	General Admin & Accounting	$128,004
2.	Medical Records	
3.	Central Supply	
4.	Scheduling	
5.	Total Salary and Wage Expense	$128,004
SECTION B - RELATED ORGANIZATION CENTRAL SERVICE COSTS		
6.	Home office costs allocated to facility	$590,511
	Name of home office: Saint John's Communities, Inc.	
	From (date): 1/1/2020	
	Through (date): 12/31/2020	
7.	County costs allocated to facility	
SECTION C - NON-SALARY EXPENSES		
8.	Purchased services - legal	$29
9.	Licensed bed assessment	40,235
10.	Contractual management fees	-
11.	Total other non-salary (from schedule 26 attachment)	70,260
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	$829,039

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Office Supplies	$1,402
2.	Computer Maintenance	30,284
3.	Dues & Subscriptions	8,024
4.	Travel & Auto	327
5.	Professional Seminars	3,172
6.	Classified Ads for Recruitment	8,605
7.	Telephone	6,394
8.	Bond Fees	718
9.	Miscellaneous	9,865
10.	Consultant Fees	1,469
11.		
12.		
13.		
14.		
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .**	**$70,260**

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) $829,039

SECTION A - DIRECT EXPENSES

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	Non-Nursing Home Areas Receiving Administrative Services		
2. Skilled Nursing Facility	$(829,039)	$829,039			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.	$(829,039)	$829,039			
16. NET UNASSIGNED EXPENSE	$-				

SECTION B - ALLOC. OF INDIRECT EXP.

	A. Total	B. NH Provider			
17. Allocation basis amounts	-				
18. Ratio to total basis to 4 decimals	1.0000	1.0000			
19. UNASSIGNED ADMIN. EXP. ALLOC	$-	-	-	-	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE	$829,039	$829,039	$-	$-	$-
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

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SCHEDULE 27: Other Cost Centers

SECTION A - SALARY AND WAGES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**			
1. TOTAL SALARY AND WAGE EXPENSE	$34,665	$59,038			
2. NUMBER OF HOURS WORKED	790 hrs.	2,476 hrs.			

SECTION B - NON-SALARY EXPENSES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	-	-	-
3. Supplies		$4,716			
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15. **TOTAL NON-SALARY EXPENSES**	$-	$4,716	$-	$-	$-

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	-	-	-
16. TOTAL EXPENSES	**$34,665**	**$63,754**			

SCHEDULE 28: Fringe Benefits

	Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1.	Employer's share of F.I.C.A.		$130,832
2.	State unemployment compensation		27,497
3.	Federal unemployemnt compensation		
4.	Worker's compensation insurance	[ ] Yes [X] No	19,569
5.	Health, Dental & Vision Insurance	[ ] Yes [X] No	266,574
6.	Life and disability insurance	[ ] Yes [X] No	4,002
7.	Wage continuation insurance	[ ] Yes [ ] No	
8.	Pension and deferred comp. plans (section C)	[X] Yes [ ] No	61,175
9.	Post-Employment Physicals and Vaccines		
10.	Uniforms		
11.			
12.			
13.			
14.			
15.	TOTAL PAID ON BEHALF OF EMPLOYEES		$509,649
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**	**$509,649**

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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					$61,175
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)	$-	$-	$-	$-	$61,175

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SCHEDULE 29: Heating and Utility Service Expenses

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	2,545
2.	Natural gas	4,321	7.	Purchased steam	
3.	L.P. gas		8.		
4.	Coal		9.		
5.	Electricity	11,055	**10.**	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$17,921**

SECTION B - ALLOCATION OF FUEL AND UTILITY EXPENSE

					Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.		
		A. Total	**B. NH Area**	**C. Emp. Unique Fringe Ben. Area**			
11.	Total square feet for areas	30,272	30,272				
12.	Ratio to total square feet to 4 decimals	1.0000	1.0000				
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**17,921**	**$17,921**	**$-**	**$-**	**$-**	**$-**
		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	$5,790
2.	Automobile insurance	☐ Yes ☒ No	909
3.	Liability insurance	☐ Yes ☒ No	55,682
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.**		**$62,381**

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.	Deferred Financing Fees-2012	1	$7,919	20	$5,189	$4,789	$399
2.	Deferred Financing Fees-2012 A	1	368	14	330	304	26
3.	Deferred Financing Fees-2015	3	25,473	30	18,998	17,659	1,339
4.	Deferred Financing Fees-2018	4	197,113	33	177,682	167,301	8,201
5.	**TOTAL AMORTIZATION EXPENSE**						**$9,965**

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SCHEDULE 30RP: Related Party Working Capital Loans

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

SCHEDULE 31RP: Related Party Accrued Insurance Expenses

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

SCHEDULE 32RP: Related Party Amortized Expenses

	A. Bond Issue	B. Sch 33RP Line Number	C. Original Amount	D. Number of Years Amortized	E. Unamortized Begin. Balance	F. Unamortized End. Balance	G. Amortization Expense
1.							
2.							
3.							
4.							
5.	**TOTAL AMORTIZATION EXPENSE**						**$-**

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SCHEDULE 33: Plant Asset Loans

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2020 Begin Bal.	E. 6Mo.date 6/30/2020 6 Mo. Bal.	F. End date 12/31/2020 End Bal.	G. Interest Rate	H. Interest Expense
1. Name WHEFA 2012 Related party? [ ] Yes [X] No Purpose Refinancing	Dec-12	Sep-32	$341,650	$280,472	$280,472	$262,465	3.22%	$8,985
2. Name WHEFA 2015 Related party? [ ] Yes [X] No Purpose Refinance 2009 WHEFA Bonds	Dec-15	Sep-45	$1,562,524	$1,455,123	$1,455,123	$1,429,892	4.82%	$53,662
3. Name WHEFA 2015 Related party? [ ] Yes [X] No Purpose Finance New Capital Expenditures	Dec-15	Sep-45	$512,903	$495,438	$495,438	$486,847	4.82%	$18,271
4. Name WHEFA 2018 A Related party? [ ] Yes [X] No Purpose Finance New SNF Construction	Apr-18	Sep-50	$20,891,035	$8,215,182	$8,215,182	$8,198,617	4.95%	$289,505
5. Name WHEFA 2018 B Related party? [ ] Yes [X] No Purpose Finance New SNF Construction	Apr-18	Apr-23	$12,055	$1,138,193	$1,138,193	$-	2.61%	$-
6. Name Related party? [ ] Yes [ ] No Purpose								
7. Name Related party? [ ] Yes [ ] No Purpose								
15 TOTAL LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2)				$11,584,408	$11,584,408	$10,377,821		$370,423

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SCHEDULE 33P2: Plant Asset Loans- Page 2

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2020 Begin Bal.	E. 6Mo.date 6/30/2020 6 Mo. Bal.	F. End date 12/31/2020 End Bal.	G. Interest Rate	H. Interest Expense
8. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
9. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
10. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
11. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
12. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
13. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
14. Name _____ Related party? ☐ Yes ☐ No Purpose _____								

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

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SCHEDULE 33RP: Related Party Plant Asset Loans

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2020 Begin Bal.	E. 6Mo.date 6/30/2020 6 Mo. Bal.	F. End date 12/31/2020 End Bal.	G. Interest Rate	H. Interest Expense
1. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
2. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
3. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
4. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
5. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
6. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
7. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
15 TOTAL RELATED PARTY LOAN PRINCIPAL AND INTEREST EXPENSE (Including Page 2).				$-	$-	$-		$-

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

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month,Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal D. Begin date 1/1/2020 Begin Bal.	E. 6Mo.date 6/30/2020 6 Mo. Bal.	F. End date 12/31/2020 End Bal.	G. Interest Rate	H. Interest Expense
8. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
9. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
10. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
11. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
12. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
13. Name _____ Related party? ☐ Yes ☐ No Purpose _____								
14. Name _____ Related party? ☐ Yes ☐ No Purpose _____								

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

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SCHEDULE 34: Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

	Begin Date 1/1/2020 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date 12/31/2020 E. Ending Balance
1. Land	156,788		( )	$156,788
2. Land Improvements	54,023		( )	54,023
3. Buildings	10,386,287	9,036,038	(6,468,909)	12,953,416
4. Leasehold Improvements	-		( )	-
5. Fixed equipment	-		( )	-
6. Moveable equipment	2,759,052	250,511	(423,821)	2,585,742
7. Transportation vehicles	55,028		( )	55,028
8. Other-CIP	-		( )	-
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$13,411,178	$9,286,549	($6,892,730)	$15,804,997

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

	A. Depreciation Method, Lives Used	Begin Date 1/1/2020 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 12/31/2020 E. Ending Balance
11. Land Improvements		$-		( )	$-
12. Buildings	SL: Bldg 35 yr, Imprv 15	7,158,844	148,047	(3,271,826)	4,035,065
13. Leasehold Improvements		-		( )	-
14. Fixed equipment		-		( )	-
15. Moveable equipment	SL 10 yr	2,106,898	52,885	(320,517)	1,839,266
16. Transportation vehicles	SL 3 yr	51,032	3,995	( )	55,027
17. Computers		236,984	15,223	((60,180))	312,387
18.				( )	-
19. TOTAL ACCUMULATED DEPRECIATION		$9,553,758		($3,532,163)	$6,241,745
20. TOTAL DEPRECIATION EXPENSE			**$220,150**		

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 1/1/2020 B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date 12/31/2020 E. Ending Balance
1.	Land	$-		( )	$-
2.	Land Improvements	-		( )	-
3.	Buildings	-		( )	-
4.	Leasehold Improvements	-		( )	-
5.	Fixed equipment	-		( )	-
6.	Moveable equipment	-		( )	-
7.	Transportation vehicles	-		( )	-
8.				( )	-
9.				( )	-
10.	TOTAL CAPITALIZED COST . .	$-	$-	($-)	$-

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

		A. Depreciation Method, Lives Used	Begin Date 1/1/2020 B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. On Disposals.	End Date 12/31/2020 E. Ending Balance
11.	Land Improvements		$-		( )	$-
12.	Buildings		-		( )	-
13.	Leasehold Improvements		-		( )	-
14.	Fixed equipment		-		( )	-
15.	Moveable equipment		-		( )	-
16.	Transportation vehicles		-		( )	-
17.					( )	-
18.					( )	-
19.	TOTAL ACCUMULATED DEPRECIATION		$-		($-)	$-
20.	**TOTAL DEPRECIATION EXPENSE**			**$-**		

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

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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.	GFC Leasing Co.	☐ Yes ☒ No	☐ Yes ☒ No	$2,000	Jan-20	Copier	$1,623
5.	Mail Finance	☐ Yes ☒ No	☐ Yes ☒ No	500	Jan-16	Postage Machine	157
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 **$1,780**

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 . . . . . **$-**

Medicaid PopID & Provider Number 839-20129300

SCHEDULE 36B: Capitalized Leases

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

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

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

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

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

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

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

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

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

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

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SCHEDULE 37: Property Taxes

SECTION A - FOR ALL PROVIDERS **Expense**

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

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

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

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

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

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

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

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

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

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

Medicaid PopID & Provider Number 839-20129300

SCHEDULE 37RP: Related Party Property Taxes

SECTION A - FOR ALL PROVIDERS **Expense**

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

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

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

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

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

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

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

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

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

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

SCHEDULE 38 - NO LONGER USED

SCHEDULE 39 - NO LONGER USED

Medicaid PopID & Provider Number 839-20129300

SCHEDULE 40: Allocated Property Expenses

				Areas for Non-NH Serv. Or Other Major Revenue-Generating Activities		
				C.	D.	E.
SECTION A - DIRECT PROPERTY EXP.		**A. Total From Sched.**	**B. NH Service Area**			
1.	Property insurance (s31)	$5,790				
2.	Mortgage insurance (s31)	-				
3.	Amortization debt premium discount (s32)	9,965				
4.	Plant asset interest expense (s33)	370,423				
5.	Depreciation land improvements (s34)	-				
6.	Depreciation buildings (s34)	148,047				
7.	Depreciation leasehold improve. (s34)	-				
8.	Depreciation fixed equipment (s34)	-				
9.	Depreciation moveable equip. (s34)	52,885				
10.	Depreciation transportation veh. (s34)	3,995				
11.	Depreciation other (s34)	15,223				
12.	Expense on operating leases (s35)	1,780				
13.	Expense on capitalized leases (s36)	-				
14.	Property taxes or fees (s37)	-				
15.	TOTAL EXPENSE	$608,108	$-			
16.	Less total directly assigned property exp.	$-				
17.	**NET UNASSIGNED/INDIRECT PROP. . . . .**	**$608,108**				
SECTION B - NON-SALARY EXPENSES		**A. Total From Sched.**	**B. NH Area**			
18.	Square feet of service's building area	30,272	30,272			
19.	Ratio to total square feet to 4 decimals	1.0000	1.0000			
20.	Indirect property expense allocation	$608,108 (from 17A)	608,108 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**	**$608,108** 17A + 20 A	**$608,108** 15B + 20B	**$-** 15C + 20C	**$-** 15D + 20D	**$-** 15E + 20E

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SCHEDULE 41: Paid Time-Off Expenses

SECTION A - POLICIES AND PRACTICES

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

2. Capitalization of plant assets - briefly describe the facility's policy or practice for the capitalization of plant assets purchases.
Purchases of property and equipment are capitalized if the cost exceeds $1,000 and the useful life exceeds three years.

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

4. Conformity - describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.
None

SECTION B - NON-PRODUCTIVE SALARY EXPENSE AND HOURS

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

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

SECTION A - RELATED PARTY LEASES

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

SECTION B - OTHER RELATED PARTY TRANSACTIONS

10.						
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 name and location of the related parties with whom the nursing home provider has transacted business with during the cost report period.

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

SCHEDULE 43A - NO LONGER USED

SCHEDULE 44 - NO LONGER USED

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

Medicaid PopID & Provider Number 839-20129300

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.	Saint John's Communities, Inc.	100%
2.		
3.		
4.		
5.		

SCHEDULE 50: Interest in Other Providers

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

SCHEDULE 51 - NO LONGER USED

Medicaid PopID & Provider Number 839-20129300

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	**$-**		

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SCHEDULE 53: Incentives – Private Room & Property

SECTION A - PRIVATE ROOM INCENTIVE

Indicate if your facility is requesting a private room incentive ☐ Yes, my facility is requesting the private room incentive.

AFFIDAVIT			
I HEREBY ATTEST and affirm that from July 1, 2021, to June 30, 2022, the _____ nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Private Room Incentive may be recouped retroactive to July 1, 2021, if the facility has charged Medicaid residents for private rooms during this period.			
SIGNATURE -	Original Signature of Officer or Administrator of Nursing Home	Title	Date

SECTION B - PROPERTY INCENTIVE

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

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