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	
North Central Health Care	715-848-4600	Bsplinter@norcen.org	
Facility Street Address	**City**	**State**	**Zip Code**
1100 Lake View Drive	Wausau	WI	54403

Contact Person	Contact Telephone Number	Contact Email Address
Bobby Splinter	715-848-4410	Bsplinter@norcen.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	20123800	1669580908	982

Administrator	Chief Financial Officer	Where are the financial records of the nursing home located?
Kristin Woller	Jill Meschke	North Central Health Care

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

Name and Title		Telephone Number	
Wipfli, LLP		715-845-3111	
Address	**City**	**State**	**Zip Code**
11 Scott Street	Wausau	WI	54402-8010
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

Effective January 1, 2020, North Central Healthcare assumed management and operation of Pine Crest Nursing Home located in Merrill, Wisconsin. The combined financial statements of North Central Health Care include inpatient and outpatient mental health services, Mount View Care Center, and Pine Crest Nursing Home which are all integrated operationally and share administrative and general, transportation, laundry, purchasing and central supply, and medical record departments. In addition, Pine Crest employees became employees of North Central Health Care effective January 1, 2021. This cost report reflects revenue and expense allocated to Mount View Care Center. A schedule detailing the allocation percentages is attached along with the Medicare cost report worksheet B-1. Schedules 10, 10A, and schedule 34 report asset, liability, and net position balances for the combined organization.

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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 [ ] (2) Voluntary Non-Profit [X] (3) Governmental

3. County of facility: Marathon — County Code: 37

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	188
Beds at End of Cost Reporting Period	12/31/2020	165
Beds in Reserve	9/1/2020	23

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.	North Central Health Care	2931	67	98	165
2.					-
3.					-
4.	TOTAL		67	98	165

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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: Pine Crest Nursing Home				x	x	x	x	
2. Hospital, Name of hospital: North Central Health Care Beds at end of cost report period: 24			x	x		x	x	x
3. Non-Medicaid Nursing Home, Beds at end of cost report period:								
4. Non-Medicaid CBRF, Beds at end of cost report period:								
5. Apartment units, Beds at end of cost report period:								
6. Room and Board - Other, Beds at end of cost report period:								
7. Therapy services, Describe: Physical, Occupational, Speech				x			x	x
8. Pharmacy				x			x	x
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)	35,610		35,610
1b.	ICF-IID Medicaid (T-19)			-
1c.	Family Care (T-19)	4,537		4,537
1d.	Other Medicaid Managed Care (T-19)			-
1e.	Hospice (T-19)	940		940
1f.	Ventilator (T-19)	2,849		2,849
2a.	Medicare (T-18)	4,187		4,187
2b.	Medicare Advantage, for days covered as a Part A stay	1,275		1,275
3a.	Private pay & Insurance	6,871		6,871
3b.	Medicare Advantage, for days not covered as a Part A stay			-
3c.	Hospice (Private pay & Insurance)	334		334
4.	Other, Specify:			
5.	TOTAL INHOUSE PATIENT DAYS	56,603	-	56,603

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**	**56,603**	**-**	**56,603**

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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. . . .	188	188	188	188	188	188	188	188	165	165	165	165	2,164
4.	Occupancy Test:													
	Row 2 x (Row 3 x 94%)	5,478	5,125	5,478	5,302	5,478	5,302	5,478	5,478	4,653	4,808	4,653	4,808	62,041
5.	Inhouse patient days	5,387	4,867	5,096	4,797	4,934	4,719	4,965	4,749	4,419	4,624	4,069	3,977	56,603
6.	Bed Hold days	-	-	-	-	-	-	-	-	-	-	-	-	-
7.	**TOTAL DAYS . . .**	5,387	4,867	5,096	4,797	4,934	4,719	4,965	4,749	4,419	4,624	4,069	3,977	56,603
		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	$4,281,037	$4,549,152
Temporary investments		
Resident accounts receivable	4,508,364	4,659,972
Other accounts receivable	4,323,794	4,977,100
Due from related parties		
Notes receivable		
Accrued interest receivable		
Inventories	409,844	429,333
Prepaid expenses	459,862	264,970
Resident funds held in trust	36,031	105,264
Other current assets, list below:		
Amounts due from Third Party Payors	-	65,603
TOTAL CURRENT ASSETS	$14,018,932	$15,051,394
PROPERTY, PLANT, EQUIP.		
Land	$51,300	$65,133
Land improvements	1,331,888	1,782,871
Buildings	15,917,415	43,059,178
Leasehold improvements	11,456,432	11,546,269
Fixed equipment	5,056,477	7,778,750
Moveable equipment	15,918,067	17,913,106
Transportation equipment	1,402,373	1,541,658
Other	6,520,293	22,971,296
Less: accumulated depreciation	(40,880,153)	(52,766,548)
TOTAL PROPERTY, PLANT, EQUIPMENT	$16,774,092	$53,891,713
OTHER		
Long term investments		
Other Assets, list below:		
Other LT Assets	18,642,063	13,626,068
Net pension asset	18,283,534	25,542,585
TOTAL OTHER ASSETS	$36,925,597	$39,168,653
TOTAL ASSETS	$67,718,621	$108,111,760

LIABILITIES AND OWNERS' EQUITY	Begin Date 1/1/20	End Date 12/31/20
CURRENT LIABILITIES		
Notes and loans payable, list below:		
Current portion of capital lease	$29,249	$27,987
Due to Marathon County for PPE	6,061,225	28,137,785
Current portion of bonds payable		2,970,000
Due to related parties		
Accounts payable	1,779,341	1,686,643
Accrued salaries	4,556,123	4,738,082
Other accrued expenses	354,936	258,959
Resident trust funds payable	36,031	88,178
Other current liabilities	109,180	61,028
TOTAL CURRENT LIABILITIES	$12,926,085	$37,968,662
LONG TERM LIAB.		
Notes and loans payable (list) below:		
Long-term portion of capital lease l	74,076	47,905
Net pension & life insurance liabilit	7,524,802	2,506,809
Long-term portion of bond payable	-	6,167,972
Other long term liabilities	9,439,717	22,225,906
TOTAL LONG TERM LIABILITIES	$17,038,595	$30,948,592
OWNER EQUITY		
OWNERS' EQUITY, list below:		
Net investment in capital assets	10,609,542	16,540,064
Unrestricted	23,931,137	15,374,265
Restricted for net pension asset	3,213,262	7,280,177
TOTAL OWNER'S EQUITY	$37,753,941	$39,194,506
TOTAL LIABILITIES AND EQUITY	$67,718,621	$108,111,760

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SCHEDULE 10A: Summary of Changes to Equity

1.	Beginning Owners' Equity (from schedule 10)			$37,753,941
2.	Add	Net income (from schedule 11, line 19)	$-	
		Owners' capital contribution	2,423,086	
		County appropriation	1,500,000	
		Net decrease in accrued vacation, holiday and sick time		
		Other, Specify: Pine Crest Beginning Net Assets	2,970,286	
		Other, Specify: Rounding	1	
		Total additions		6,893,373
3.	Deduct	Net loss (from schedule 11, line 19)	($3,366,771)	
		Dividends and withdrawals	( )	
		Net increase in accrued vacation, holiday and sick time	( )	
		Other, Specify: Hospital and Pine Crest Loss	(2,086,037)	
		Other, Specify:	( )	
		Total deductions		(5,452,808)
4.	**ENDING OWNERS' EQUITY (schedule 10).**			$39,194,506

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	$ 19,995,838
2.	Service fees	schedule 15, line 14A	-
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	65
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	10,307
14.	Other revenue	schedule 18, line 50	4,248,931
15.	Subtract: deductions from revenues	schedule 14, line 5	(5,322,007)
16.	NET REVENUES		$ 18,933,134

SECTION B - SUMMARY OF NET INCOME OR LOSS

17.	Subtract: total expenses	schedule 12, line 37	$ (22,299,905)
18.	Add or subtract the amount to adjust related party transactions to cost	schedule 42, line 15	-
19.	**NET INCOME OR LOSS**		$ **(3,366,771)**

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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	$7,997,631
2. Laboratory & Radiology	S21, L13a	-
3. Respiratory	S21, L13b	600,769
4. Pharmacy	S21, L13c	120,000
5. PT, OT and Speech	S22, L13a	732,041
6. Dental	S22, L13b	-
7. Physician	S22, L13c	178,668
8. Social Services	S23, L13a	207,804
9. Recreational Activities	S23, L13b	239,179
10. Religious Services	S23, L13c	-
11. Volunteer Coordinator	S24, L13a	49,774
12. Ward Clerks	S24, L13b	69,470
13. Psychotherapy	S24, L13c	-
14. Other	S24, L13d	
15. Dietary	S25, L14a	1,327,190
16. Plant Operations and Maintenance	S25, L14b	1,037,177
17. Housekeeping	S25, L14c	494,216
18. Laundry and Linen	S25, L14d	150,471
19. Security	S25, L14e	-

Cost Center	Reference	Expense
20. Transportation	S25, L14f	$1,502
21. Administrative service expense	S26, L12	2,966,617
Other cost centers, Specify:		
22. Nurse Aide Training	S27, L16a	
23. Beauty/Barber Shop	S27, L16b	
24. 0	S27, L16c	
25. 0	S27, L16d	
26. 0	S27, L16e	
UNASSIGNED EXPENSES		
27. Employee fringe benefit expense	S28, L17	4,295,373
28. Heating fuel and utility expense	S29, L10	373,027
29. Interest on operating working capital loans	S30, L6	-
30. Insurance expense	S31, L9	150,967
31. Amortization expense	S32, L5	-
32. Interest on plant asset loans	S33, L15h	-
33. Depreciation expense	S34, L20c	1,307,620
34. Expense on operating and non-cap.leases	S35, L14	-
35. Expense on capitalized leases	S36A, L5	409
36. Property tax expense	S37, L7	-
37. TOTAL EXPENSES FOR REPORT PERIOD		$22,299,905

(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	$7,056,196	Dietary	S25, L1a	761,540
Laboratory & Radiology	S21, L1a	-	Plant operation / maintenance	S25, L1b	-
Respiratory	S21, L1b & 3b	600,769	Housekeeping	S25, L1c	475,401
Pharmacy	S21, L1c & 3c	-	Laundry and Linen	S25, L1d	110,487
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	1,696,387
Social Services	S23, L3a	207,804	Nurse aide training	S27, L1a	-
Recreational Activities	S23, L3b	221,456	Beauty and barber	S27, L1b	-
Religious Services	S23, L3c	-	Other, Specify: 0	S27, L1c	-
Volunteer Coordinator	S24, L3a	49,774	0	S27, L1d	-
Ward Clerks	S24, L3b	69,470	0	S27, L1e	-
Psychotherapy	S24, L1c & 3c	-	**TOTAL SALARY AND WAGE EXPENSE**		$11,249,284
Other	S24, L1d & 3d	-			

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SCHEDULE 14: Daily Patient Service Revenues

SECTION A - DAILY RATE CHARGES	**Revenue**
1. Medicare Daily Rate	$3,408,494
2. Medicaid Daily Rate (including bed hold)	14,236,917
3. Private Pay	2,350,427
4. Medical Supplies,Other	

SECTION B - Deductions From Revenue	
5. TOTAL DEDUCTIONS FROM REVENUE	(5,322,007)

SECTION C - TOTAL	
6. TOTAL DAILY PATIENT SERVICE REVENUE	$14,673,831

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 $295.00
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				
4.	Physical therapy				
5.	Speech/hearing therapy				
6.	Occupational therapy				
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	$-	$-	$-	

SECTION B - THERAPY REVENUES

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

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

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 ☐ No If yes, amount of revenue

20. Does your facility or related organization bill Medicare Part B for therapy services at your facility? ☐ Yes ☐ No If yes, amount of revenue

21. Did you charge rent to a rehabilitation agency or independent contractor? ☐ Yes ☐ 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					
10.	Gift Shop	65				
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**	**$65**				

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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	$10,307
	OTHER REVENUES	
46.	Supplemental Payment	$2,818,703
47.	CARES Act Revenue	1,426,288
48.	Other Departmental and Miscellaneous Revenue	3,940
49.		
50.	TOTAL OTHER REVENUES	$4,248,931

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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	$3,370,036	$573,915	$3,112,245	$7,056,196
2. TOTAL SALARY AND WAGE HOURS	98,355 hrs.	24,386 hrs.	185,404 hrs.	$308,145
3. EXPENSE FOR PURCHASED SERVICES	$86,760			$86,760
AVERAGE WAGE PER HOUR	$34.26	$23.53	$16.79	$22.90

NURSING AND INCONTINENCY SUPPLIES		
4. Catheters, Incontinency Supplies (including purchased laundry service)		$126,610
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		289,204
7. Nonbillable over the counter (OTC) drugs for all residents (include billable OTC drugs on Schedule 21, Line 9c)		135,694
8. Equipment Rental and Contracted Services		201,189
9. Supplies and Other		101,978
10. TOTAL DAILY PATIENT SERVICE EXPENSE		**$7,997,631**

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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	$-	$600,769	
4.	Number of hours worked - Non-billable	hrs.	20,381 hrs.	
5.	TOTAL SALARY AND WAGE EXPENSE	$-	$600,769	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable			
7.	Expense for purchased service - Non billable	$-		$120,000
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Pharmacy - legend drugs Billable	$-	$-	
9.	Pharmacy - over the counter drugs Billable	$-	$-	
10.	Supply and Other			
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES**	**$-**	**$600,769**	**$120,000**
14.	**TOTAL HOURS**	**hrs.**	**20,381 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	$732,041		
7.	Expense for purchased service - Non billable			$178,668
SECTION C - SUPPLY AND OTHER EXPENSE				
8.				
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	TOTAL EXPENSES	$732,041	$-	$178,668
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	$207,804	$221,456	
4.	Number of hours worked - Non-billable	7,752 hrs.	10,120 hrs.	
5.	TOTAL SALARY AND WAGE EXPENSE	$207,804	$221,456	$-
SECTION B - PURCHASED SERVICES				
6.	Expense for purchased service - Billable	$-	$-	$-
7.	Expense for purchased service - Non billable			
SECTION C - SUPPLY AND OTHER EXPENSE				
8.	Supplies		$17,723	
9.				
10.				
11.				
12.				
SECTION D - TOTAL				
13.	**TOTAL EXPENSES . . . . . .**	**$207,804**	**$239,179**	**$-**
14.	**TOTAL HOURS . . . . . .**	**7,752 hrs.**	**10,120 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**	**Hospital/PC/Other**
1.	Expense for hours worked - Billable	$-	$-		
2.	Number of hours worked - Billable	hrs.	hrs.		
3.	Expense for hours worked - Non-billable	$49,774	$69,470		
4.	Number of hours worked - Non-billable	2,080 hrs.	4,100 hrs.		
5.	TOTAL SALARY AND WAGE EXPENSE	$49,774	$69,470	$-	$-
SECTION B - PURCHASED SERVICES					
6.	Expense for purchased service - Billable				
7.	Expense for purchased service - Non billable				
SECTION C - SUPPLY AND OTHER EXPENSE					
8.					
9.					
10.					
11.					
12.					
SECTION D - TOTAL					
13.	**TOTAL EXPENSES**	$49,774	$69,470	$-	
14.	**TOTAL HOURS**	2,080 hrs.	4,100 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	$761,540		$475,401	$110,487		
2. NUMBER OF HOURS WORKED	48,437 hrs.		32,186 hrs.	7,615 hrs.		
SECTION B - DIETICIAN CONSULTANT						
3. Dietician consultant expense		$-	$-	$-	$-	$-
SECTION C - OUTSIDE SERVICE						
4. Contracted Services		$1,012,554	$9,870			
5.						
6.						
7.						
8. **TOTAL OUTSIDE SERVICE EXPENSES**	$-	$1,012,554	$9,870	$-	$-	$-
SECTION D - SUPPLY AND OTHER EXPENSE						
9. Food	$505,063					
10. Supplies and Other	60,587	90	8,945	23,226		1,502
11. Linen and Bedding				16,758		
12. Equipment Repair		24,533				
13.						
SECTION E - TOTAL						
14. TOTAL EXPENSES	**$1,327,190**	**$1,037,177**	**$494,216**	**$150,471**	**$-**	**$1,502**

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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)	$1,327,190
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)	$1,327,190

		A. Total	B. Residents' Meals	C. Employees' Meals	D. Meals on Wheels	E.Other	F. Other
6.	Meals served	1	1				
7.	Ratio to total meals served to 4 decimals	1.0000	1.0000				
8.	DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	$1,327,190 From line 5	$1,327,190 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	1	1				
13.	Ratio to total square feet to 4 decimals . .	1.0000	1.0000				
14.	TOTAL PATIENT OP/MAINT EXP. ALLOC.	$1,037,177 From S25, L18	$1,037,177 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	1	1			
16.	Ratio to total sq. ft./hours to 4 decimals	1.0000	1.0000			
17.	TOTAL HOUSEKEEPING EXP. ALLOC.	$494,216	$494,216	$-	$-	$-
		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	1	1			
19.	Ratio to total pounds to 4 decimals	1.0000	1.0000			
20.	TOTAL LAUNDRY/LINEN EXP. ALLOC.	$150,471	$150,471	$-	$-	$-
		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: driver time	1	1			
25.	Ratio to total alloc. basis to 4 decimals	1.0000	1.0000			
26.	TOTAL TRANS. EXPENSE ALLOC.	$1,502	$1,502	$-	$-	$-
		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	$1,667,971
2.	Medical Records	28,416
3.	Central Supply	
4.	Scheduling	
5.	Total Salary and Wage Expense	$1,696,387
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	15,054
SECTION C - NON-SALARY EXPENSES		
8.	Purchased services - legal	$27,523
9.	Licensed bed assessment	371,790
10.	Contractual management fees	
11.	Total other non-salary (from schedule 26 attachment)	855,863
SECTION D - TOTAL		
12.	TOTAL ADMINISTRATIVE SERVICE EXPENSES	$2,966,617

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

	Description of Other Non-Salary Administrative Service Expenses	Expense Amount
1.	Contracted Services - IT	$266,154
2.	General Supplies and Other	355,526
3.	Contracted Services and Maintenance Agreements (Non-IT)	121,556
4.	Supplies	92,426
5.	Advertising	20,201
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.	**TOTAL OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES (to Sch 26, Line 11) . . . . . .**	**$855,863**

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	15,054
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	$15,054

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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) $2,966,617

SECTION A - DIRECT EXPENSES

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	Non-Nursing Home Areas Receiving Administrative Services: Hospital/PC/Other		
2. Bed Assessment	$(371,790)	$371,790			
3.	-				
4.	-				
5.	-				
6.	-				
7.	-				
8.	-				
9.	-				
10.	-				
11.	-				
12.	-				
13.	-				
14.	-				
15. TOTAL DIRECT EXPENSE.	$(371,790)	$371,790			
16. NET UNASSIGNED EXPENSE	$2,594,827				

SECTION B - ALLOC. OF INDIRECT EXP.

	A. Total	B. NH Provider	Hospital/PC/Other		
17. Allocation basis amounts	1	1			
18. Ratio to total basis to 4 decimals	1.0000	1.0000			
19. UNASSIGNED ADMIN. EXP. ALLOC	$2,594,827	2,594,827	-	-	-
	net from line 16	19A x 18B	19A x 18C	19A x 18D	19A x 18E
20. TOTAL ADMINISTRATIVE EXPENSE	$2,966,617	$2,966,617	$-	$-	$-
	(line 15A + 19A)	B15 + B19	C15 + C19	D15 + D19	E15 + E19

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SCHEDULE 27: Other Cost Centers

SECTION A - SALARY AND WAGES	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**			
1. TOTAL SALARY AND WAGE EXPENSE					
2. NUMBER OF HOURS WORKED					

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

SECTION C - TOTAL	**A. Nurse Aide Training**	**B. Beauty/Barber Shop**	-	-	-
16. TOTAL EXPENSES					

SCHEDULE 28: Fringe Benefits

	Fringe Benefits Paid on Behalf of Employees	Self-Funded?	Expense
1.	Employer's share of F.I.C.A.		$814,456
2.	State unemployment compensation		21,042
3.	Federal unemployemnt compensation		
4.	Worker's compensation insurance	[ ] Yes [X] No	91,762
5.	Health, Dental & Vision Insurance	[X] Yes [ ] No	2,357,616
6.	Life and disability insurance	[ ] Yes [X] No	8,201
7.	Wage continuation insurance	[ ] Yes [X] No	-
8.	Pension and deferred comp. plans (section C)	[ ] Yes [X] No	852,368
9.	Post-Employment Physicals and Vaccines		
10.	Uniforms		
11.	Employee Benefits - accrued PLT		151,563
12.	Other		(1,635)
13.			
14.			
15.	TOTAL PAID ON BEHALF OF EMPLOYEES		$4,295,373
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**	**$4,295,373**

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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		$2,555,447			
2	Premium costs for re-insurance (stop loss) policies purchased from an unrelated party		206,227			
3	Costs paid to administer the self insurance plan not reported elsewhere in the cost report		182,215			
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		518,523			
7	Proceeds from re-insurance (stop loss) policies, dividend proceeds, and audit adjustment cost decreases or (increases)		67,750			
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)	$-	$2,357,616	$-	$-	$-

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SCHEDULE 29: Heating and Utility Service Expenses

SECTION A - ACCRUED EXPENSE BY TYPE

		Accrued Expense			Accrued Expense
1.	Fuel oil		6.	Water and sewer utility charges	38,578
2.	Natural gas	120,011	7.	Purchased steam	
3.	L.P. gas		8.		
4.	Coal		9.		
5.	Electricity	214,438	**10.**	**TOTAL FUEL AND UTILITY EXPENSE . . .**	**$373,027**

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	1	1				
12.	Ratio to total square feet to 4 decimals	1.0000	1.0000				
13.	**TOTAL ALLOC. FUEL/UTIL. EXPENSE**	**373,027**	**$373,027**	**$-**	**$-**	**$-**	**$-**
		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	$35,303
2.	Automobile insurance	☐ Yes ☒ No	32,628
3.	Liability insurance	☐ Yes ☒ No	82,712
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 — Bond Insurance	☐ Yes ☒ No	324
9.	**TOTAL INSURANCE EXPENSE**		**$150,967**

SCHEDULE 32: Amortized Expenses

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

SCHEDULE 30RP: Related Party Working Capital Loans

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

SCHEDULE 31RP: Related Party Accrued Insurance Expenses

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

SCHEDULE 32RP: Related Party Amortized Expenses

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

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SCHEDULE 33: Plant Asset Loans

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

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SCHEDULE 33P2: Plant Asset Loans- Page 2

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

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

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SCHEDULE 33RP: Related Party Plant Asset Loans

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

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

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

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

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	51,300	13,833	(-)	$65,133
2. Land Improvements	1,331,888	454,531	(3,548)	1,782,871
3. Buildings	15,917,415	27,141,763	(-)	43,059,178
4. Leasehold Improvements	11,456,432	125,175	(35,338)	11,546,269
5. Fixed equipment	5,056,477	2,765,238	(42,964)	7,778,751
6. Moveable equipment	15,918,067	2,105,863	(110,825)	17,913,105
7. Transportation vehicles	1,402,373	151,843	(12,559)	1,541,657
8. Capitalized Lease Equipment	130,361	-	(-)	130,361
9.			( )	-
10. TOTAL CAPITALIZED COST . .	$51,264,313	$32,758,246	($205,234)	$83,817,325

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	SL 8-40	$1,418,419	$49,913	($3,548)	$1,464,784
12. Buildings	SL 40	20,690,041	981,019	(-)	21,671,060
13. Leasehold Improvements	SL 10-40	8,379,227	190,841	(22,506)	8,547,562
14. Fixed equipment	SL 10-40	4,798,183	930,972	(21,777)	5,707,378
15. Moveable equipment	SL 5-20	13,625,944	967,710	(86,415)	14,507,239
16. Transportation vehicles		699,472	125,739	(12,559)	812,652
17. Capitalized Lease Equipment	SL 5	27,937	27,937	(-)	55,874
18. Depreciation not related to MVCC		-	(1,966,511)	((1,966,511))	-
19. TOTAL ACCUMULATED DEPRECIATION		$49,639,223		($(1,819,706))	$52,766,549
20. TOTAL DEPRECIATION EXPENSE			**$1,307,620**		

21. Cost of Bariatric Equipment included with Additions reported above purchased during this cost report period $12,529

Medicaid PopID & Provider Number 982-20123800

SCHEDULE 34RP: Related Party Depreciation Expenses

SECTION A - CAPITALIZED HISTORICAL COST

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

SECTION B - DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION

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

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

Medicaid PopID & Provider Number 982-20123800

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 $-

Medicaid PopID & Provider Number 982-20123800

SCHEDULE 36A: Capitalized Leases

SECTION A - CAPITALIZED LEASE INFORMATION

Lease Expense

1. Name of lessor: Marco
   Is lessor a related party? . . . . . ☐ Yes ☒ No
   Beginning Lease Date: 1/1/2019
   Ending Lease Date: 8/31/2023
   Is this a lease purchase agreement? ☐ Yes ☒ No
   Description of leased property: Multifunctional Devices (printer, fax, scanner

   1a. Amortization of capitalized lease value
   1b. Interest expense on capital lease obligation: 409
   1c. Accrued contingent lease payments for period . . .
   1d. SUBTOTAL LEASE EXPENSE: $409

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 $409

Medicaid PopID & Provider Number 982-20123800

SCHEDULE 36B: Capitalized Leases

SECTION B - ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES

A1. Name of lessor: Marco
A2. Actual payments required by lease in report period $29,249
A3. Are any capitalized costs reported on other schedules? . . . . . ☐ Yes ☒ No
A4. If yes, (schedule) 34 (line) 20 (amount) $16,782

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 $29,249

Medicaid PopID & Provider Number 982-20123800

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 982-20123800

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 982-20123800

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.	D.	E.
1. Property insurance (s31)	$35,303				
2. Mortgage insurance (s31)	-				
3. Amortization debt premium discount (s32)	-				
4. Plant asset interest expense (s33)	-				
5. Depreciation land improvements (s34)	49,913				
6. Depreciation buildings (s34)	981,019				
7. Depreciation leasehold improve. (s34)	190,841				
8. Depreciation fixed equipment (s34)	930,972				
9. Depreciation moveable equip. (s34)	967,710				
10. Depreciation transportation veh. (s34)	125,739				
11. Depreciation other (s34)	(1,938,574)				
12. Expense on operating leases (s35)	-				
13. Expense on capitalized leases (s36)	409				
14. Property taxes or fees (s37)	-				
15. TOTAL EXPENSE	$1,343,332	$-			
16. Less total directly assigned property exp.	$-				
17. NET UNASSIGNED/INDIRECT PROP.	**$1,343,332**				

SECTION B - NON-SALARY EXPENSES	A. Total From Sched.	B. NH Area	C.	D.	E.
18. Square feet of service's building area	1	1			
19. Ratio to total square feet to 4 decimals	1.0000	1.0000			
20. Indirect property expense allocation	$1,343,332 (from 17A)	1,343,332 20A x 19B	- 20A x 19C	- 20A x 19D	- 20A x 19E

SECTION C - TOTAL	A. Total From Sched.	B. NH Area	C.	D.	E.
21. TOTAL PROP. EXP. FOR EACH AREA	**$1,343,332** 17A + 20 A	**$1,343,332** 15B + 20B	**$-** 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.
Equipment purchased for less than $2,500 is expensed. Equipment purchased for $2,500 or more, with a useful life of more than two years, is capitalized according to American Hospital Association guidelines.

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 employee hours are not reported in 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.
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	27,523	A&G	26	2	8
13. Owner or key person life insurance					
14. Taxes					
15. Fund raising expenses					
16. Excess property					
17. Out of State Travel (Destination)	2,960	A&G	26ATT	2	2
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 982-20123800

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.	None	0%
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.	Pine Crest Nursing Home	Nursing Home	Operated as consolidated entity
2.			
3.			
4.			
5.			

SCHEDULE 51 - NO LONGER USED

Medicaid PopID & Provider Number 982-20123800

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

[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 North Central Health Care 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? [x] YES