STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES

FORM 12 - CAPITAL RECONCILIATION

Facility Name			
D/B/A (If Applicable)			
Provider Number	Period: From	To	
Total Capital at Beginning of Period (Form 11, Line 42, Column 1)			$
Additions to Capital			
1. Net Income for Period (Form 5, Line 26)		$	
2. Contributions to Capital (include date and amount of each transaction)			
Transaction Date	Transaction Amount		
3.			
4.			
Total Additions to Capital			
Subtotal			
Reductions to Capital			
1. Dividends Paid			
2. Owners' Withdrawals (include date and amount of each transaction)			
Transaction Date	Transaction Amount		
3.			
4.			
Total Reductions to Capital			
Total Capital at End of Reporting Period (Form 11, Line 42, Column 2)			$

Revised 03/14/10
DOM 500-0

DIVISION OF MEDICAID - LONG-TERM CARE FACILITY COST REPORT REVIEW CHECKLIST

This Checklist Must Be Submitted to Medicaid With the Cost Report

Facility Name:

D/B/A (If Applicable)

Provider Number: Period: From To

FORM/SCHEDULE	REFERENCE	YES	N/A
Form 1, General Information			
Management Agreement			
Form 2, Certification by Officer or Administrator of Provider			
Original Signature	Must be Signed By Officer or Administrator		
Form 3, Statistical Data			
Form 4, Patient Day Statistics			
Form 5, Statement of Revenues and Expense			
Form 6, pages 1-4, Schedule of Expenses			
Form 7, pages 1-2, Schedule of Fixed Assets & Depreciation			
Form 8, Facility Transactions with Related Organizations			
Form 9, Rental of Vehicles and Property			
Form 10, Analysis of Interest Bearing Debt & Related Interest Expense			
Form 11, pages 1-2, Balance Sheet			
Form 12, Capital Reconciliation	Net Income must match Form 5, Line 26		
Form 13, pages 1-3, Return on Equity	Column 1 balances must tie to Form 11		
Form 14, pages 1-3, Computation of Per Diem Cost for Facilities with Less Than 80% Occupancy	Must be completed if % of occupancy is less than 80% on Form 4		
Form 15, pages 1-3, Owners, Officers and Directors Compensation	A separate Form 15 must be submitted for each owner or officer (regardless of the compensation) and for each director receiving compensation other than director fees.		
Form 16, Ownership disclosure			
Form 17, pages 1-2, Home Office/Related Management Company Cost Report			
Form 18, Computation of Return on Net Working Capital for Home Office			
Schedule 1, Other Income	Must agree with Form 5, Line 15		
Schedule 2, Direct Care Allocated Costs	Must agree with Form 6, Line 1-17		
Schedule 3, Therapy Allocated Costs	Must agree with Form 6, Line 2-16		
Schedule 4, Care Related Allocated Costs	Must agree with Form 6, Line 3-22		
Schedule 5, Miscellaneous Expense	Must agree with Form 6, Line 4-37		
Schedule 6, Administrative & Operating Allocated Costs	Must agree with Form 6, Line 4-47		
Schedule 7, Property & Equipment Allocated Costs	Must agree with Form 6, Line 5-08		
Schedule 8, Other Non-allowable Costs	Must agree with Form 6, Line 6-12		
Schedule 9, Form 6 Cost Variances	Must provide explanation for all positive variances greater than 10% and $1,000		
Schedule 10, Deposits	Must agree with Form 11, Page 1, Line 19		
Schedule 11, Home Office/Related Management Company Other Income	Must agree with Form 17, Line 1-08		
Schedule 12, Home Office/Related Management Company Other Expense	Must agree with Form 17, Line 2-27		
Depreciation schedule	Must support Form 7 and Form 17, Line 2-13		
Trial Balance	Must tie to Form 5 and Form 6, Column 1 and to Form 11, Column 2		
Adjustments workpapers			
Amortization schedule	Must support Form 6, Lines 4-23 and 5-01 and Form 17, Line 2-10		
Hold Harmless Documentation	Must be submitted if facility receives hold harmless payment		
Medicare c/r sch. A, A-6, A-7,A-8,A-8-1,B Part 1, B-1	Must be submitted if facility is hospital based or state-owned with allocated costs.		
Other attached schedules			

I certify that all of the above forms, schedules and other supporting information marked "YES" are included in the submission of the Medicaid cost report to the Division of Medicaid.

Signature Title Date

DOM 500-5

Revised 02/26/2010

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES

FORM 5 - STATEMENT OF REVENUES AND EXPENSES

Facility Name

D/B/A (If Applicable)

Provider Number Period: From To

DESCRIPTION	Column 1 PER GENERAL LEDGER	Column 2 Medicaid Certified Portion of Long Term Care Facility	Column 3 ADJUSTMENT TO FORM 6 COLUMN 4	Column 4 LINE NUMBER REFERENCE FOR ADJUSTMENT
Patient Revenues				
1. a. Medicare Part A Revenue				
b. Allowances and Discounts on Patients' Accounts				
2. a. Medicaid Revenue				
b. Allowances and Discounts on Patients' Accounts				
3. a. Other Patient Revenue				
b. Allowances and Discounts on Patients' Accounts				
4. Net Patient Revenues				
5. Total Operating Expenses (Form 6, Line 7, Column 1)				
6. Net Income from Services to Patients				
OTHER INCOME				
7. Barber and Beauty Income				
8. Contributions, Gifts, Grants, etc.				
9. Feeding Assistant Training Reimbursement				
10. Guest & Employee Meals Revenue				
11. Interest Income				
12. Nurse Aide Training & Testing Reimbursement				
13. Nursing Supplies				
14. Other Ancillary Services Revenue Including Medicaid Crossover Payments				
15. Other Income (Schedule 1)				
16. Occupational Therapy Income				
17. Pharmacy Revenue				
18. Physical Therapy Income				
19. Rental Income				
20. Respiratory Therapy Income				
21. Speech Therapy Income				
22. State Appropriations				
23. Television, Telephone Income				
24. Vending Machines Revenue				
25. Total Other Income	$	$		
26. Net Income (Total of Lines 6 and 25) (Form 12, Line 1)	$			

DOM 501-1

Revised 03/11/2010

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID
LONG-TERM CARE FACILITIES

SCHEDULE 1 - OTHER INCOME (FORM 5, LINE 15)

Facility Name				
D/B/A (If Applicable)				
Provider Number	Period: From		To	
DESCRIPTION	Column 1 PER GENERAL LEDGER	Column 2 Medicaid Certified Portion of Long Term Care Facility	Column 3 ADJUSTMENT TO FORM 6 COLUMN 4	Column 4 FORM 6 LINE # ADJUSTED
Total (Must agree with Form 5, Line 15)	$	$	$	

SCHEDULE 1

Effective May 27, 2010

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Instructions

The cost reporting forms and schedules described below must be used by all Mississippi long-term care facilities participating in the Mississippi Medicaid Program (Title XIX). Medicare (Title XVIII) cost reporting forms are not acceptable in lieu of these forms. Hospital based facilities and state owned facilities which use the Medicare forms for step-down in completing their cost report must submit a copy of the applicable Medicare cost report forms.

General Information

These instructions are for use in the preparation and submission of the cost report to the Division of Medicaid by all Mississippi long-term care facilities providing care and services under the Medical Assistance Program, including nursing facilities, intermediate care facilities for the mentally retarded (ICF-MR) and psychiatric residential treatment facilities (PRTF).

The annual reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the facility for no less than three years following the date reports are submitted to the Division of Medicaid. **All dollar amounts must be rounded to the nearest dollar and must foot and crossfoot. Only per diem cost amounts will not be rounded.** Cost reports submitted that have not been rounded in accordance with this policy will be returned to the provider and will not be considered as received until they are re-submitted.

Annual Reporting

Reports are to be filed with the Division of Medicaid on or before the last day of the fifth month following the close of the provider's reporting period. Should the due date fall on a Saturday, Sunday, State of Mississippi holiday or federal holiday, the due date shall be the following business day.

The cost reports must be mailed or delivered to:

Bureau of Reimbursement
Division of Medicaid
Office of the Governor
Suite 1000, Walter Sillers Building
550 High Street
Jackson, MS 39201

The following documentation must be submitted with the cost reports:

(a) working trial balance(s) of all entities reported on the cost report

forms with the appropriate cost report line numbers to which each account can be traced. This should be done by running a trial balance in cost report line number order that subtotals the accounts by cost report line number. The subtotals should tie to each cost report line;

(b) depreciation schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted. If the facility has home office costs, a copy of the home office depreciation schedule must also be submitted. All hospital-based facilities must submit a depreciation schedule that clearly shows and totals assets that are hospital only, NF only and shared assets. All Medicaid-basis facility depreciation schedules must be sorted by the asset categories on Form 7 and subtotaled by year of acquisition;

(c) amortization schedule(s), if applicable;

(d) narrative description of purchased management services or a copy of contracts for managed services, if applicable;

(e) a description of the basis used to allocate the home office or related management company costs to providers of the group and to non-provider activities, if applicable, and a copy of the cost allocation worksheets;

(f) hospital based and state facilities must submit all allocation worksheets. The Medicare schedules that must be submitted for facilities using the Medicare forms for allocation are: Worksheet A, Reclassification and Adjustment of Trial Balance of Expenses; Worksheet A-6, Reclassifications; Worksheet A-7, Capital Analysis and Reconciliation; Worksheet A-8, Adjustments to Expenses; Worksheet A-8-1, Statement of Costs of Services From Related Organizations; Worksheet B, Part 1, Cost Allocation - General Service Costs; and Worksheet B-1, Cost Allocation - Statistical Basis;

(g) Hold harmless documentation that describes why the facility is unable to lower its property costs for facilities receiving the hold harmless payment for property. This may include a copy of the facility's mortgage that disallows early payments, bonds that can not be refinanced, leases, etc. Failure to submit documentation will disqualify a facility from eligibility for the hold harmless provision.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Cost reports must be submitted on or before the due date in order to avoid a penalty in the amount of $50.00 per day each day the cost report is delinquent. The submission date will be verified by postmark, delivery ticket, or date hand delivered.

When it is determined that a cost report does not include the checklist, all required forms and schedules, and documentation listed in items (a) through (g) of this section, the provider will be notified. The provider must submit a complete cost report. If the request is made and the completed cost report is not received on or before the due date of the cost report, or is not received within 24 hours of the request if made after the due date, the provider will be subject to the penalties for filing delinquent cost reports.

When it is determined that additional information is needed, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made and five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted and be considered for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of financial review, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Allowable costs will be adjusted to disallow any expenses or cost findings that are not submitted.

Accounting Basis

The report must be prepared on the accrual basis of accounting. If a facility is on a cash basis, it will be necessary to convert from a cash to an accrual basis for reporting purposes. This does not apply to governmental facilities.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Particular attention must be given to an accurate accrual of all costs at the end of the reporting period for the equitable distribution of costs to the applicable period. Care must be given to the proper allocation of costs for service and maintenance contracts to the period covered by such contracts. Care should be given to a proper cutoff of accounts receivable and accounts payable both at the beginning and ending of the reporting year. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the reporting period.

Supporting Information

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. The report is based on financial and statistical records which must be maintained by the facility for three (3) years from the date submitted to the Division of Mississippi. Cost information must be current, accurate, and in sufficient detail to support the claim for reasonable cost-related reimbursement. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. Census data on the cost report must be supported by daily census records, patient's charts, etc. Such information must be adequate and available for auditing.

Amended Cost Reports

The Division of Medicaid accepts amended cost reports for a period of eighteen (18) months following the end of the reporting period. Form 1, Section II must be completed on all amended cost reports in order to explain the reason for the amendment. Form 2 with an original signature certifying that the amended information is correct and all amended supporting related information must be submitted. Each form and schedule submitted must be clearly marked "Amended". Amended cost reports submitted after the annual base rate is determined will be used only to adjust the individual provider's rate, if necessary. Amended cost reports will not be accepted for the following: a) on or after the date that Medicaid financial review field work begins, b) to submit additional information for costs previously disallowed due to failure to respond to a request for information, or c) for submission of detailed expense descriptions for which costs were disallowed because non-acceptable descriptions were used.

Instructions for Cost Report Forms

CHECKLIST

Complete, sign and submit the checklist. Check "YES" or "N/A" for all items. All items marked "YES" must be submitted with the cost report.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

When it is determined in accordance with cost report instructions that certain form(s) and schedule(s) are not required to be filed, the "N/A" column should be checked. The items marked N/A in accordance with cost report instructions do not have to be submitted.

FORM 1 GENERAL INFORMATION

I. Facility Name:

The name of the long-term care facility as licensed by the Mississippi State Department of Health.

Provider Number:

The facility's Medicaid provider number in effect for the dates of the cost report.

D/B/A:

The name by which the long-term care facility operates (complete only if different from facility name above).

Administrator, MS License Number:

The facility's administrator at the close of the cost reporting period.

E-Mail Address:

Enter the facility e-mail address, if available, Administrator or contact person

Contact Person:

The person who should be contacted regarding the cost report.

All Correspondence and Desk Reviews Regarding This Cost Report Should Be Addressed To (Limited to one name and address):

List the name, address, telephone number and fax number of the person to whom all correspondence, desk reviews, financial reviews, etc. should be addressed. Each facility is allowed only one name and address in this section.

II. Complete this section only if the facility is filing an amended cost report. The reason for the amendment must be clearly stated and each cost report form being amended must be marked "**AMENDED**" at the top of each form. Each amended cost report must include Forms 1 and 2 as well as the applicable forms

and schedules being amended.

III. Complete this section if the General Ledger of the Medicaid-certified nursing facility also accounts for other entities. Examples of other entities are hospital, rural health clinic, outpatient therapy services, non-Medicaid certified nursing facility, and personal care home.

IV. Complete this section only if the facility has a home office/related management company. In addition, facilities claiming home office costs/related management fees must complete Form 17 and Schedules 11 and 12. Facilities with a home office must also complete Form 18.

V. Complete this section if the facility employs a management company. A narrative description of purchased management services or a copy of contracts for managed services must be submitted with the cost report in order for management fees to be allowed.

VI. For DOM use only.

FORM 2 CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

The Certification by Officer or Administrator of Provider is required and must be signed by an authorized officer or the administrator of the facility. The cost report will not be deemed received by the Division of Medicaid if this certification has not been completed.

The cost report may be completed by the facility's employees, owners, independent accountants, or other qualified parties. The name and address of the preparer as well as the name and telephone number of a contact person must be completed on Form 2.

FORM 3 STATISTICAL DATA

Lines 1, 2, 3 and 4

Please check the appropriate blocks that apply to your facility. Please check only one block on each of lines 1, 3, and 4. Line 2 must have a box checked on each of lines A, B and C.

A facility is part of a chain if the facility owner(s) also owns another one or more separate long-term care facilities.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

A hospital-based nursing facility is defined as a nursing facility that is either physically located in a hospital or is owned or controlled by a hospital and all of the nursing facility costs are included in the hospital's Medicare cost report and the nursing facility receives overhead allocated from the hospital.

Please check blocks on Line 2 D, Column 1 so that all entity types reported in the general ledger are marked "yes". Columns 2, 3, 4 and 5 must be completed if "yes" is marked in Column 1.

Column 1	Check yes if the entity type is reported in the general ledger.
Column 2	Enter the number of patient days related to the particular use of the facility.
Column 3	Enter the number of beds related to the particular use of the facility.
Column 4	Enter the square footage related to the particular use of the facility.
Column 5	Enter the shared square footage related to the particular use of the facility. If square footage is reported in this column, attach detail which explains with which area the square footage is shared and by how much.

Enter the total square footage of the facility on Line 2E.

Line 5

Patient Days. Complete the number of patient days by type of patient. Include only statistics for Medicaid-certified beds. Do not include statistics for personal care beds, for example. Column (a) Total Patient Days, Column (b) Medicaid Patient Days, Column (c) Medicare Patient Days, Column (d) Private Pay Patient Days, Column (e) Other – all other patient days.

Holding and leave days are to be included in patient days. Residents of long-term care facilities are considered Medicaid only when Medicaid is the primary payer for that day. For example, if a resident is Medicare/Medicaid, the days that Medicaid pays the Medicare co-insurance are counted as Medicare days for statistical purposes.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Lines 6, 7 and 8

Enter the number of beds certified for Medicaid at the beginning of the period on Line 6 in the first block. If there was no change in the number of Medicaid certified beds during the cost report period, enter the ending number of beds in the first block of Line 7. Temporary changes because of alterations, repairs, etc. do not affect bed capacity. Show any changes to the number of Medicaid-certified beds in blocks 2, 3 and 4. Show the effective date of each change on Line 8.

Line 9

Compute the total certified bed days available during the period by multiplying the number of beds available for the period by the number of days in the period. Any increase or decrease in the number of beds must be taken into consideration as well as the number of days elapsed during each increase or decrease.

Line 10

The percentage of occupancy for the cost report period should be computed by dividing the total patient days from Line 5, Column A by the bed days available on Line 9. This number must be rounded to two (2) decimal places (example: 98.57%)

Line 11

The percentage of Medicaid utilization is the total Medicaid days from Line 5, Column B divided by the total patient days from Line 5, Column A. This number must be rounded to two (2) decimal places (Example: 78.94%).

FORM 4 PATIENT DAY STATISTICS

SECTION I

Include only statistics for Medicaid-certified beds in this section. Do not include non-Medicaid certified beds statistics on Form 4 (example: personal care beds).

Residents of long-term care facilities are considered Medicaid only when Medicaid is the primary payer for that day. For example, if a resident is Medicare/Medicaid, the days in which Medicaid pays the Medicare co-insurance would be considered Medicare days for statistical purposes.

Holding and leave days are to be included in patient days. Data for months 13 through

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

15 in the cost reporting period must be combined and reported with the twelfth month's data.

Column 1 List each Calendar month included in the cost reporting period.

Column 2 List the Medicaid patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column B.

Column 3 List Medicare patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column C.

Column 4 List private pay patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column D.

Column 5 List all other types of patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column E.

Column 6 Total of Columns 2, 3, 4, and 5. The total of this column must agree with Form 3, Line 5, Column A.

Column 7 List the total number of bed days available for each month by multiplying the number of certified beds by the number of days in the month.

Column 8 Enter the Total Patient Days in Column 6 divided by the Bed Days Available in Column 7 for each line. The percentage must be rounded to two (2) decimal places (Example: 99.75%).

SECTION II.

List the facility's private pay rates for both private rooms and semi-private rooms. The list should include all rates that were effective during the reporting period.

FORM 5 STATEMENT OF REVENUES AND EXPENSES

All revenue is to be entered on the appropriate line in Column 1 and must agree with the revenue recorded in the general ledger. If the facility has a non-Medicaid certified portion of a facility, the total line item amounts per the general ledger must be recorded in Column 1. The portion of the line item amounts from the general ledger that apply to the Medicaid participating portion of the long term care facility must be recorded in

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Column 2. Adjustments to the revenue accounts must be entered in Column 3. Enter the line number reference for each adjustment in Column 4.

Revenue cost findings must be submitted on a separate schedule which shows the computation of cost and the basis for the computation. The purpose of a cost finding is to identify costs associated with generating a specific revenue. Failure to submit adequate cost findings for other income or the sources and/or uses of contributions, gifts and grants will result in the revenues being offset against cost. A cost finding includes, but is not limited to, direct salaries and fringe benefits, indirect salaries and fringe benefits (ex. billing clerk), contractual fees, consulting fees, supplies, utilities, and capital costs, including property taxes, insurance and depreciation incurred to generate the revenue. Cost allocations, when necessary, should be based on Medicare guidelines published in CMS Publication 15-1. All costs identified in the cost findings are non-allowable costs and must be offset against the appropriate line of Form 6, Column 4. Revenue offsets should not create a negative adjusted balance on the referenced cost line of Form 6, Column 5. When the cost finding is not submitted or is incomplete, revenue offsets in excess of referenced costs should be taken to Form 6, Line 4-37, which may have a negative adjusted balance in Column 5.

Line 1.a. Medicare Part A Revenue

Enter all patient revenues for room and board received for Medicare Part A stays. This income for the Part A per diem includes any ancillaries paid for through the per diem rate on Line 1.

Line 1.b. Allowances and Discounts on Patients' Accounts

Enter the allowances and discounts on patients' accounts pertaining to Medicare Part A revenue. This includes contractual adjustments for revenue reported on Line 1.a. only.

Line 2.a. Medicaid Revenues

Enter all patient revenues for room and board received for Medicaid stays. Revenues received for items billed outside the room and board charge (i.e. durable medical equipment, drugs, etc.) for Medicaid stays should be included in the Other Income section of Form 5.

Line 2.b. Allowances and Discounts on Patients' Accounts

Enter the allowances and discounts on patients' accounts. This includes contractual adjustments for revenue reported on Line 2.a. only.

INSTRUCTIONS FOR FILING
LONG-TERM CARE FACILITY COST REPORT

Line 3.a. Other Patient Revenues

Enter other patient revenues for room and board (for stays other than Medicare or Medicaid). Revenues received for items billed outside the room and board charge (i.e. durable medical equipment, drugs, etc.) should be included in the Other Income section of Form 5.

Line 3.b. Allowances and Discounts on Patients' Accounts

Enter the allowances and discounts on patients' accounts. This includes contractual adjustments for revenue reported on Line 3.a. only.

Line 4. Net Patient Revenues

Lines 1.a., 2.a., and 3.a. less Lines 1.b, 2.b, and 3.b.

Line 5. Total Operating Expenses

Column 1 must agree with Form 6, Line 7, Column 1.

Line 6. Net Income from Services to Patients

Line 4 less Line 5.

Contractual adjustments related to revenue reported on Lines 7 - 24 must be netted against the related revenue.

Line 7. Barber and Beauty Income:

Enter all barber and beauty income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made first to Form 6, Line 6-03, then Line 3-13.

Line 8. Contributions, Gifts, Grants, etc.:

Enter all contributions, gifts and grants income on this line. An offset of income against allowable costs is not required for unrestricted contributions, gifts and grants. For restricted contributions, gifts and grants, revenue must be matched to costs and offset against those costs. The source and/or purpose of contributions, gifts and grants must be disclosed when the cost report is submitted.

Line 9. Feeding Assistant Training Reimbursement:

Enter the feeding assistant training reimbursement on this line. All feeding

assistant training expense must be reported on Form 6, Line 6-05. Refer to facility records and Division of Medicaid summary reports for expense amounts.

Line 10. Guest and Employee Meals Revenue:

Enter all guest and employee meals revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 3-20.

Line 11. Interest Income:

Enter all interest income on this line. The adjustment entered in Column 3 should be the lesser of reported interest income or interest expense. Interest income must be offset first against interest expense reported on Form 6, Line 4-33 and then Form 6, Line 5-03.

Line 12. Nurse Aide Training and Testing Reimbursement:

Enter the nurse aide training and testing reimbursement on this line. All nurse aide training and testing expense must be reported on Form 6, Lines 6-09 and 6-10. Refer to facility records and Division of Medicaid summary reports for expense amounts.

Line 13. Nursing Supplies:

Enter all nursing supplies revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 1-15, then Line 1-17.

Line 14. Other Ancillary Services Revenue Including Medicaid Crossover Payments:

Enter all ancillary services revenue (ex. durable medical equipment) which is not more appropriately reported on another line of Form 5. Oxygen (Inhalation Therapy) Revenue should also be reported on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 1.

Line 15. Other Income:

Enter all income on this line which is not more appropriately reported on another

line. All income must be listed on Schedule 1. Enter an adjustment in Column 3 for the amount of the cost findings. If the facility does not submit cost findings with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to lines on Form 6 as deemed appropriate.

Line 16. Occupational Therapy Income:

Enter all occupational therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

Line 17. Pharmacy Revenue:

Enter all pharmacy revenue on this line. A revenue offset is not required for pharmacy revenue. Instead, the criteria for determining allowable pharmacy expenses on the cost report must be followed.

Line 18. Physical Therapy Income:

Enter all physical therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

Line 19. Rental Income:

Enter all rental income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Lines 5-06 and 5-07.

Line 20. Respiratory Therapy Income:

Enter all respiratory therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct

the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

Line 21. Speech Therapy Income:

Enter all speech therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2 of the cost report. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

Line 22. State Appropriations:

Enter all state appropriations on this line. No offset is required.

Line 23. Television, Telephone Income:

Enter all television and telephone income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Lines 6-14 and 4-46 for television and to Line 4-44 for telephone.

Line 24. Vending Machines Revenue:

Enter all vending machines revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 6-15 and then Line 4-46. However, if the revenue is from commissions only, no offset of revenue is required.

Line 25

The sum of Lines 7 through 24.

Line 26

The sum of Lines 6 and 25. Line 26 must agree with Form 12, Line 1.

FORM 6 SCHEDULE OF EXPENSES

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Column 1 Enter the expenses per the general ledger on the appropriate line.

Line 7 of this column must agree with Form 5, Line 5. **This column must agree with the trial balance included with the cost report.**

Column 2 This column is for any reclassification that should be made between expenses. For example, all costs not associated with the Medicaid-certified portion of the Long-term Care Facility must be reclassified in Column 2 to Line 6-08, Non-Medicaid Long-term Care Costs. The total for Column 2 on Line 7 must be zero. A schedule must be attached to describe any reclassifications made.

Facilities which have a portion of the facility that is not certified for Medicaid must allocate the costs associated with that portion of the facility as non-allowable costs. These costs must be allocated based on square footage for fixed costs (i.e. utilities, depreciation, interest), actual salaries and fringe benefits of employees working in the non-certified area, and based on patient days for non-direct costs (i.e. administrative costs, dietary costs), or other methods which are acceptable by Medicare per CMS Publication 15-1 guidelines.

Column 3 Column 1 plus or minus Column 2.

Column 4 Adjustments to expenses must be entered in Column 4. These adjustments should include excess owner's compensation, excess related party expenses, excess dues, excess owner's relatives compensation, excess board of directors fees, revenue offsets, etc. A schedule must be attached to describe any adjustments made.

Column 5 Column 3 plus or minus Column 4. Form 6 must foot and crossfoot. All problems with rounding must be corrected before the cost report is submitted.

Line 1 Direct Care Expenses

Costs of the direct care of medical services must be included in Section 1, Line 1-01 through 1-18. Lines 1-05 through 1-10 are employee benefits for the direct care employees.

Line 1-01, Salaries-Aides

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Gross salary of certified nurse aides and nurse aides in training.

Line 1-02, Salaries-LPN's
Gross salaries of licensed practical nurses and graduate practical nurses.

Line 1-03, Salaries-RN's (exclude DON and RAI Coordinator)
Gross salaries of registered nurses and graduate nurses (excluding the DON and Resident Assessment Instrument Coordinator).

Line 1-04, Salaries-Feeding Assistants
Gross salary of feeding assistants.

Line 1-05, FICA-Direct Care
Cost of employer's portion of Social Security Tax and Medicare for direct care employees.

Line 1-06, Group Insurance-Direct Care
Cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.

Line 1-07, Pensions-Direct Care
Cost of employer's contribution to employee pensions for direct care employees.

Line 1-08, Unemployment Taxes-Direct Care
Cost of employer's contribution to State and Federal unemployment taxes for direct care employees.

Line 1-09, Uniform Allowance-Direct Care
Employer's cost of uniform allowance and/or uniforms for direct care employees.

Line 1-10, Workmen's Comp-Direct Care
Cost of workmen's compensation insurance for direct care employees.

Line 1-11, Contract-Aides
Cost of aides hired through contract who are not facility employees.

Line 1-12, Contract-LPN's
Cost of LPN's and graduate practical nurses hired through contract who

are not facility employees.

Line 1-13, Contract-RN's

Cost of RN's and graduate nurses hired through contract who are not facility employees.

Line 1-14, Drugs-Allowable

If a drug is covered by the Medicaid drug program, the cost of the drug is not allowable on the cost report for any resident, regardless of payor source (Medicaid, Medicare Part A, private, VA). In addition, if a drug is in a class eligible for payment by a Medicare Part D plan and the resident is or could be eligible to receive Part D benefits, the cost of the drug is non-allowable on the cost report. Accordingly, if a drug provided to a non-Medicaid resident (Medicare Part A or private) would have been covered by Medicaid or Medicare Part D if the resident were on a Medicaid stay, the related cost is not allowable on the cost report.

The cost of bulk drug purchases of over-the-counter drugs (stock drugs) for distribution to any facility resident is allowable on cost report Line 1-14.

Non-allowable drug costs must be reported on or reclassified to Line 6-14.

Line 1-15, Medical Supplies-Direct Care

Cost of patient specific items of medical supplies such as catheters, syringes, and sterile dressings.

Line 1-16, Medical Waste Disposal

Cost of medical waste disposal including storage containers and disposal costs.

Line 1-17, Other Supplies Direct Care

Cost of items used in the direct care of residents that are not patient specific such as prep supplies, alcohol pads, Betadine solution in bulk, tongue depressors, cotton balls, thermometers, and blood pressure cuffs.

Line 1-18, Allocated Costs-Hospital Based and State Facilities

Direct Care costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs on this line must complete Schedule 2.

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Line 1-19, Total Direct Care Costs
Line 1-19 is the sum of Line 1-01 through Line 1-18.

Line 2 Therapy Expenses

Costs attributable to the administering of therapy services must be included in Section 2, Lines 2-01 through 2-16. Lines 2-05 through 2-10 are employee benefits for therapy salaries.

Line 2-01, Salaries-Occupational Therapists
Gross salaries of occupational therapists.

Line 2-02, Salaries-Physical Therapists
Gross salaries of physical therapists.

Line 2-03, Salaries-Speech Therapists
Gross salaries of speech therapists.

Line 2-04, Salaries-Other Therapists
Gross salaries of therapists other than occupational therapists, physical therapists and speech therapists, including but not limited to, respiratory therapists.

Line 2-05, FICA-Therapies
Cost of employer's portion of Social Security Tax and Medicare for therapy employees.

Line 2-06, Group Insurance-Therapies
Cost of employer's contribution to employee health, life, accident and disability insurance for therapy employees.

Line 2-07, Pensions-Therapies
Cost of employer's contribution to employee pensions for therapy employees.

Line 2-08, Unemployment Taxes-Therapies
Cost of employer's contribution to State and Federal unemployment taxes for therapy employees.

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Line 2-09, Uniform Allowance-Therapies

Employer's cost of uniform allowance and/or uniforms for therapy employees.

Line 2-10, Workmen's Comp-Therapies

Cost of workmen's compensation insurance for therapy employees.

Line 2-11, Contract-Occupational Therapists

Cost of occupational therapists hired through contract who are not facility employees.

Line 2-12, Contract-Physical Therapists

Cost of physical therapists hired through contract who are not facility employees.

Line 2-13, Contract-Speech Therapists

Cost of speech therapists hired through contract who are not facility employees.

Line 2-14, Contract-Other Therapists

Cost of therapists other than occupational therapists, physical therapists and speech therapists hired through contract that are not facility employees, including but not limited to, respiratory therapists.

Line 2-15, Therapy Costs - Other

All other costs incurred for rendering direct therapeutic service to the residents of the facility, including but not limited to dues, educational seminars and training, licenses, supplies and travel. Non-direct costs, i.e. attendance at seminars not directly related to rendering therapeutic services and related travel expense, should be reported in Section 4 of Form 6.

Line 2-16, Allocated Costs-Hospital Based and State Facilities

Therapy costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 3.

Line 2-17, Total Therapy Costs

Line 2-17 is the sum of Line 2-01 through 2-16.

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Line 3 Care Related Expenses

Care related services include activities, director and assistant director of nursing, medical director, pharmacy, and social services. Employee benefits for these salaries must be included on Lines 3-07 through 3-12. Supplies for care related services and certain personal hygiene items must be included on Line 3-22.

Line 3-01, Salaries-Activities

Gross salaries of personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of the residents.

Line 3-02, Salaries-Assistant Director of Nursing

Gross salary of the Assistant Director of Nursing.

Line 3-03, Salaries-Director of Nursing

Gross salary of the Director of Nursing.

Line 3-04, Salaries-Resident Assessment Instrument Coordinator

Gross salary of the Resident Assessment Instrument Coordinator.

Line 3-05, Salaries-Pharmacy

A portion of pharmacy salaries is allowable based on an allocation of prescriptions dispensed that represent allowable drug costs on Line 1-14 to total drugs dispensed by the pharmacy. The allocation calculation must be enclosed with the cost report. Pharmacy salaries will not be allowable related to bulk drug purchases.

Allocation calculation example: A hospital pharmacy related to a hospital-based nursing facility prepared 300,000 prescriptions during the cost report period. 36 prescriptions were dispensed for which the related costs are allowable on the nursing facility cost report Line 1-14. No other prescriptions dispensed for nursing facility residents are allowable on Line 1-14. The pharmacy salaries total $100,000. The allowable allocation of pharmacy salaries is $12, calculated as follows: 36 / 300,000 * $100,000.

Line 3-06, Salaries-Social Services

Gross salaries of personnel providing medically-related social services to

attain or maintain the highest practicable physical, mental or psychosocial well-being of the residents.

Line 3-07, FICA-Care Related

Cost of employer's portion of Social Security Tax and Medicare for care related employees.

Line 3-08, Group Insurance-Care Related

Cost of employer's contribution to employee health, life, accident and disability insurance for care related employees.

Line 3-09, Pensions-Care Related

Cost of employer's contribution to employee pensions for care related employees.

Line 3-10, Unemployment Taxes-Care Related

Cost of employer's contribution to State and Federal unemployment taxes for care related employees.

Line 3-11, Uniform Allowance-Care Related

Employer's cost of uniform allowance and/or uniforms for care related employees.

Line 3-12, Workmen's Comp-Care Related

Cost of workmen's compensation insurance for care related employees.

Line 3-13, Barber and Beauty Expense - Allowable

The cost of barber and beauty services provided to residents for which no charge is made.

Line 3-14, Consultant Fees-Activities

Fees paid to activities personnel, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-15, Consultant Fees-Medical Director

Fees paid to a medical doctor, not on the facility payroll, for providing advisory, educational and emergency medical services to the facility.

Line 3-16, Consultant Fees-Nursing

Fees paid to nursing personnel, not on the facility payroll, for providing

advisory and educational services to the facility.

Line 3-17, Consultant Fees-Pharmacy

Fees paid to a registered pharmacist, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-18, Consultant Fees-Social Worker

Fees paid to a social worker, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-19, Consultant Fees - Therapists

Fees paid to licensed therapists, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-20, Food

Cost of food products used to provide meals and snacks to residents, including enteral feeding. Hospital based facilities and state owned facilities must allocate Food based on the number of meals served.

Line 3-21, Supplies - Care Related

The cost of supplies used by the care related staff for rendering care related services to the residents of the facility. Certain personal hygiene items such as shampoo and soap administered by all staff must be included on this line.

Line 3-22, Allocated Costs-Hospital Based and State Facilities

Care Related costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 4.

Line 3-23, Total Care Related Costs

Line 3-23 is the sum of Line 3-01 through Line 3-22.

Line 4 Administrative and Operating Costs

Administration, dietary, housekeeping, laundry, maintenance, and medical records salaries and expenses must be included in this section of the cost report. Lines 4-10 through 4-15 are for employee benefits for administration and operating salary classifications. Lines 4-16 through 4-46 capture other

administrative and operating costs for the entire facility operation. For example, travel and training expenses incurred by all facility departments are reported on Line 4. (See exception explained on the instructions for Form 6, Line 2-15.)

Line 4-01, Salaries - Administrator

Gross salary of licensed administrators excluding owners. Hospital based facilities and state owned facilities must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing facility, ICF-MR or PRTF.

Line 4-02, Salaries - Assistant Administrator

Gross salary of licensed assistant administrators excluding owners.

Line 4-03, Salaries - Dietary

Gross salaries of kitchen personnel including dietary supervisor, cooks, helpers and dishwashers.

Line 4-04, Salaries - Housekeeping

Gross salaries of housekeeping personnel including housekeeping supervisors, maids and janitors.

Line 4-05, Salaries - Laundry

Gross salaries of laundry personnel.

Line 4-06, Salaries - Maintenance

Gross salaries of personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineer.

Line 4-07, Salaries - Medical Records

Gross salaries of medical records personnel.

Line 4-08, Salaries - Other Administrative

Gross salaries of other administrative personnel including bookkeeper, receptionist, administrative assistants and other office and clerical personnel.

Line 4-09, Salaries - Owner or Owner/Administrator

Gross salaries of all owners of the facility that are paid through the facility.

The allocation of owners' salaries between facilities should be calculated

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following these guidelines:

The paid salary must be reduced to the allowable limit for the year or portion, thereof, if payment exceeded the Medicaid limit. The allowable salary must then be allocated to the various facilities based on hours spent at each facility to total hours worked on all facilities. Total hours used in the calculation must be no more than sixty (60) and no less than forty (40). When the various facilities differ in classification, the limit applicable to each facility classification should be used and allocated.

Example Data:

1997 Salary Paid to Owner was $350,000.

1997 Salary Limits:	Small N.Facility	- $61,824
	Large N.Facility	- $81,410
	ICF-MR	- $40,533

Example 1:

Nursing Facility A, Small	60 Beds	30 hours worked per week
Nursing Facility B, Small	60 Beds	35 hours worked per week
Total	120 Beds	65 hours

Limit for Nursing Facility A:
Hours: 30/65 x 60 = 28
$61,824 x 28/60 = $28,851
Limit for Nursing Facility B:
Hours: 35/65 x 60 = 32
$61,824 x 32/60 = $32,973
Total: $61,824

Example 2:

Nursing Facility A, Small	60 Beds	10 hours worked per week
Nursing Facility B, Large	90 Beds	20 hours worked per week
ICF-MR Facility	75 Beds	15 hours worked per week
Non Related Work	N/A	15 hours worked per week
Totals	225 Beds	60 hours

Total Facility hours worked was 45.
Limit for Nursing Facility A, Small: $61,824 x 10/45 = $13,739

Limit for Nursing Facility B, Large: $81,410 x 20/45 = $36,182

Limit for ICF-MR: $40,533 x 15/45 = $13,511

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Example 3:

Nursing Facility A, Small 60 Beds, 30 Beds Medicaid Certified
40 Hours Worked

Limit for Nursing Facility A: $61,824 x 30/60 beds = $30,912

Line 4-10, FICA - Administration and Operating

Cost of employer's portion of Social Security Tax and Medicare for administration and operating employees.

Line 4-11, Group Insurance - Administration and Operating

Cost of employer's contribution to employee health, life, accident and disability insurance for administration and operating employees.

Line 4-12, Pensions-Administration and Operating

Cost of employer's contribution to employee pensions for administration and operating employees.

Line 4-13, Unemployment Taxes-Administration and Operating

Cost of employer's contribution to State and Federal unemployment taxes for administration and operating employees.

Line 4-14, Uniform Allowance-Administration and Operating

Employer's cost of uniform allowance and/or uniforms for administration and operating employees.

Line 4-15, Workmen's Comp-Administration and Operating

Cost of workmen's compensation insurance for administration and operating employees.

Line 4-16, Contract - Dietary

Cost of dietary services and personnel hired through contract who are not facility employees.

Line 4-17, Contract-Housekeeping

Cost of housekeeping services and personnel hired through contract who are not facility employees.

Line 4-18, Contract - Laundry

Cost of laundry services and personnel hired through contract who are not

facility employees.

Line 4-19, Contract - Maintenance

Cost of maintenance services and personnel hired through contract who are not facility employees.

Line 4-20, Consultant Fees - Dietician

Fees paid to consulting registered dieticians.

Line 4-21, Consultant Fees - Medical Records

Fees paid to consulting medical records Accredited Records Technicians or Medical Records Administrators.

Line 4-22, Accounting Fees

Fees incurred for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services, excluding personal tax planning and personal tax return preparation.

Line 4-23, Amortization Expense - Non-Capital

Costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of sixty months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

Line 4-24, Auto Lease

Cost of lease for vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both patient care purposes and personal purposes, cost must be allocated based on the mileage log. Form 9, Section I must be completed for leased vehicles.

Line 4-25, Bank Service Charges

Fees paid to banks for service charges on business bank accounts, including resident trust fund accounts. Penalties and insufficient funds charges are non-allowable. Fees for personal bank accounts are also non-allowable.

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Line 4-26, Board of Directors Fees

Fees paid to members of the facility board of directors for attending directors meetings. The name, title, address, percentage of ownership and amount of compensation must be reported on Form 16.

Line 4-27, Dietary Supplies

Costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc. used in the dietary department.

Line 4-28, Depreciation

Capital expenditures on or after January 1, 1992 of more than $500 and less than the new bed value for the calendar year of purchase should be depreciated over 3 to 5 years and expensed on this line. **Depreciation expense of assets depreciated on this line will not be allowable beyond five (5) years from the date the assets were placed in service**. To determine if the capital expenditures reach or exceed the new bed value, the capitalized assets which cost over $500, other than vehicles, should be added together. If the sum of capital expenditures for the calendar year is less than the new bed value, then all of the assets should be depreciated over 3 to 5 years and expensed on this line. All facility vehicles depreciation must be expensed on this line, regardless of the purchase date. The facility must maintain a mileage log for each vehicle. If a vehicle is used for purposes other than patient care purposes, the facility must allocate the portion used for non-patient care purposes to non-allowable costs based on the mileage log. The mileage records for owned vehicles must be reported on Form 7, Section IV. Depreciation included on this line must be excluded from Line 5-02. Facilities which capitalize assets costing less than $500 and which exceed the bed value for that year should depreciate those assets for 3 to 5 years on Line 5-02. Administrative and operating depreciation expense must be reported in Section I, Column 5 of Form 7.

Line 4-29, Dues

Dues for professional, technical, or business related organizations and dues for civic organizations. The portion of dues associated with lobbying activities is unallowable and must be reclassified to Line 6-12.

Line 4-30, Educational Seminars and Training

The cost of registration for attending educational seminars and training by

employees of the facility and costs incurred in the provision of in-house training for facility staff. The cost of any travel incurred to attend an educational seminar must be included on Line 4-45, Travel.

Line 4-31, Housekeeping Supplies

Cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

Line 4-32, Insurance-Professional Liability and Other

Includes the cost of insuring the facility against injury and malpractice claims and the cost of vehicle insurance. The cost of property insurance, other than vehicles, must be reported on Line 5-04.

Line 4-33, Interest Expense - Non-Capital and Vehicles

Interest paid on short term borrowing for facility operations and on vehicle loans must be reported on Line 4-33. Column 1 of Line 4-33 must agree with the total column of Form 10, Line 10.

Line 4-34, Laundry Supplies

Cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

Line 4-35, Legal Fees

Fees paid to attorneys in accordance with other provisions of the State Plan.

Line 4-36, Linen and Laundry Alternatives

Cost of sheets, blankets, pillows, gowns, underpads and diapers (reusable and disposable).

Line 4-37, Miscellaneous

Costs incurred in providing facility services that cannot be assigned to any other line item on Form 6. Examples of miscellaneous expense are non-capitalized equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, allowable advertising, flowers and plants purchased for facility common areas, allowable litigation deductibles and settlements, and costs to treat employee injuries not covered by worker's compensation insurance. Routine lab and x-ray costs incurred by psychiatric residential treatment facilities must be reported on this line. The physician fee for a physical

exam after PRTF admission must be reported on this line. Expenses incurred by ICF-MR's for dental diagnostic and treatment services must be reported on this line. This line should also include excess revenue offsets that cannot be made to the line on Form 6 related to the revenue without creating a credit balance for that line. Line 4-37 may have a credit balance in Column 5. The expenses included on this line must be reported on Schedule 5. Expenditures for $500 or less may be reported on one line of Schedule 5.

Line 4-38, Management Fees and Home Office Costs

The cost of purchased management services or home office costs incurred that are allocable to the provider. Costs included that are for related management/home office costs must also be reported on Form 8 and Form 17. **No management fees or home office costs are allowed to be reclassed to other lines on the cost report.**

Line 4-39, Non-Emergency Medical Transportation

The cost of purchased non-emergency medical transportation services including, but not limited to, payments to employees for use of personal vehicle, ambulance companies and other transportation companies for transporting residents of the facility.

Line 4-40, Office Supplies and Subscriptions

Cost of consumable goods used in the business office such as pencils, paper, and computer supplies. Cost of forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, facility letterhead and billing forms. Cost of subscribing to newspapers, magazines and periodicals.

Line 4-41, Postage

Cost of postage, including stamps, metered postage, freight charges and courier services.

Line 4-42, Repairs and Maintenance

Supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the facility building, furniture and equipment. This includes computer software maintenance and gas and oil for facility vehicles.

Line 4-43, Taxes & Licenses

The cost of taxes and licenses that are not included on any other line on Form 6. This includes tags for vehicles, the Medicaid bed tax and licenses for facility staff (including nurse aide recertifications) and buildings.

Line 4-44, Telephone and Communications

Cost of telephone services, WATS lines and FAX services.

Line 4-45, Travel

Cost of travel (airfare, lodging, meals, etc.) by the Administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct facility business.

In-town meals are not allowable. The in-town area includes the surrounding metropolitan area for a facility located in a metropolitan area. For example, meals and lodging expenses in Jackson for a facility in Brandon are not allowable. Commuting expenses and travel allowances are not allowable. Relocating and moving expenses are not allowable.

The expenses of a company airplane and its pilot are allowable to the extent that the prudent buyer concept is met. The flight log, a list of employees on each flight, and a calculation of cost per flight hour must be submitted with the cost report in order for allowability of costs to be considered. Costs to be included in the calculation, but not necessarily on reported on this line, include, but are not limited to, fuel, depreciation, interest, maintenance, hangar fees and pilot costs. In addition, a comparison of these costs to commercial airfare and/or travel by vehicle must be submitted.

Line 4-46, Utilities

Cost of water, sewer, gas, electricity, cable TV and garbage collection services.

Line 4-47, Allocated Costs-Hospital Based and State Facilities

Administrative and Operating costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 6.

Line 4-48, Total Administrative and Operating Costs

Line 4-48 is the sum of Line 4-01 through Line 4-47.

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Line 5 Property and Equipment

Property costs, excluding vehicles and those capitalized assets which total less than a new bed value in any year, must be included in Lines 5-01 through 5-08.

Line 5-01, Amortization Expense-Capital

Legal and other costs incurred when financing the facility must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

Line 5-02, Depreciation

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. The depreciation expense incurred on capital expenditures which exceed the new bed value for the year must be reported on this line. These assets will be used to recalculate the age of the facility. To determine if the capital expenditures reach or exceed the new bed value, the capitalized assets which cost over $500, other than vehicles, should be added together. The depreciation expense incurred on vehicles must be reported on or reclassified to Line 4-28. All assets except for vehicles capitalized prior to January 1, 1992 are considered as part of the facility value calculated at the start of the fair rental system and any current expense for these assets must be reported on Line 5-02. Property and equipment depreciation expense reported in Section I, Column 6 of Form 7.

Line 5-03, Interest Expense - Capital

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facility's land, buildings and/or furniture and equipment, excluding vehicles. Column 1 of Line 5-03 must agree with the total column of Form 10, Line 9.

Line 5-04, Property Insurance

Cost of fire and casualty insurance on facility buildings and equipment, excluding vehicles. Hospital based facilities and state owned facilities

must allocate Property Insurance based on the number of square feet.

Line 5-05, Property Taxes

Taxes levied on the facility's land, buildings, furniture and equipment, excluding vehicles. Hospital based facilities and state owned facilities must allocate Property Taxes based on the number of square feet.

Line 5-06, Rent - Building

Cost of leasing the facility's real property. Form 9, Section II must be completed.

Line 5-07, Rent - Furniture and Equipment

Cost of leasing the facility's furniture and equipment, excluding vehicles.

Line 5-08, Allocated Costs-Hospital Based and State Facilities

Property costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 7.

Line 5-09, Total Property and Equipment

Line 5-09 is the sum of Line 5-01 through Line 5-08. These totals are automatically calculated.

Line 6 Non-Allowable Costs

Costs which are not related to patient care or are considered non-allowable costs in accordance with Attachment 4.19-D of the Medicaid State Plan must be included on Line 6-01 through 6-15.

Line 6-01, Advertising

Costs of advertising to the general public which seeks to increase patient utilization of the nursing facility

Line 6-02, Bad Debts

Accounts receivable written off as uncollectible.

Line 6-03, Barber and Beauty Expense

Costs directly related to the provision of barber and beauty services to residents. The costs of barber and beauty services provided for which the

residents are not charged are considered allowable costs, such as routine shampoos and haircuts. The allowable barber and beauty costs must be included on Line 3-13, Barber & Beauty Expense - Allowable.

Line 6-04, Contributions

Amounts donated to charitable or other organizations and political contributions.

Line 6-05, Feeding Assistant Training

All costs incurred in training feeding assistants in order to meet 42 CFR, Section 483.35 (4) (2) provisions. Due to the federal stipulation that these expenses qualify only for the Medicaid administrative match, these expenses can not be allowed on the cost report. This includes both the Medicaid and non-Medicaid portion of the expenses. Costs that are not eligible or are not submitted to the Division of Medicaid for direct reimbursement must also be included on this line.

Line 6-06, Income Taxes - State and Federal

Taxes on net income levied or expected to be levied by the Federal or State government.

Line 6-07, Insurance - Officers

Cost of insurance on officers and key employees of the facility when not provided to all employees or is otherwise allowed by the State Plan.

Line 6-08, Non-Medicaid Long Term Care Costs

Costs allocated to portions of a facility that are not licensed as the reporting nursing facility, ICF-MR or PRTF or are not certified to participate in Title XIX. For all hospital based facilities using a combined general ledger, this line must include all general ledger expenses not reported on any other line on Form 6.

Line 6-09 and 6-10, Nurse Aide Testing and Training

All costs incurred in having nurse aides tested or trained in order to meet OBRA 1987 provisions that may have been or will be submitted to the Division of Medicaid for direct reimbursement. This includes both the Medicaid and non-Medicaid portion of the expenses. Example - A nursing facility incurs $1,000 in allowable expenses for nurse aide training. A bill is submitted to the Division of Medicaid for direct reimbursement. Based on the facility's percentage of Medicaid utilization, the facility was eligible

for 80% reimbursement. A payment was made to the facility in the amount of $800 ($1,000 X 80%) for the Medicaid portion of the nurse aide training expense. The $1,000 should be included in non-allowable costs and the $800 reimbursement should be included on Form 5, Line 12. Costs incurred by facilities that are not submitted to the Division of Medicaid for direct reimbursement by the deadline for submission must also be included on this line.

Line 6-11, Other Non-Allowable Costs

Other costs that are considered non-allowable in accordance with other provisions of the State Plan (products sold to residents, amortization of goodwill, depreciation expense on assets with a basis in excess of the Medicaid basis, lab and radiology for residents, recruiting other than advertising, relocating and moving expenses, etc.). Costs included on this line must be reported on Schedule 8.

Line 6-12 Penalties & Sanctions

Penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, Division of Medicaid, the Internal Revenue Service or the State Tax Commission, insufficient funds charges, late fees, etc.

Line 6-13, Pharmacy

Cost of drugs not allowable on Line 1-14.

Line 6-14, Television

Cost of television sets used in the residents' rooms or for providing cable TV to the residents' rooms for which a fee is charged to the residents.

Line 6-15, Vending Machines

Cost of items sold to employees, residents and the general public including candy bars and soft drinks.

Line 6-16, Total Non-Allowable Costs

Line 6-16 is the sum of Line 6-01 through Line 6-15.

Line 7 Total Costs

Line 7, Column 1 must agree with the total expenses in the general ledger and Form 5, Line 5, Column 1. For hospital based facilities using a combined general ledger, Line 7, Column 1 must tie to Schedule A, Column 3 of the hospital cost report.

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Line 8 Total Patient Days

Enter the number of total patient days from Form 3, Line 5, Column A.

Computation of Allowable Cost Per Day

Enter the total allowable cost for each line from column 5 of the appropriate cost center on Form 6 in Column A. Column B is the allowable cost per day which is computed by dividing the amount in Column A by Line 8.

Line 9, Direct Care Costs

Column A must agree with Line 1-19, Column 5.

Line 10, Therapy Costs

Column A must agree with Line 2-17, Column 5.

Line 11, Care Related Costs

Column A must agree with Line 3-23, Column 5.

Line 12, Administrative and Operating Costs

Column A must agree with Line 4-48, Column 5.

Line 13, Property Costs

Column A must agree with Line 5-09, Column 5.

Line 14, Total Costs

Column A is the sum of Line 9 through Line 13 and must agree with Line 7, Column 5. Column B is the sum of Line 9 through Line 13.

Facilities with less than 80% occupancy for the cost reporting period must also complete Form 14.

FORM 7 SCHEDULE OF FIXED ASSETS AND DEPRECIATION

Use this form to report the totals from the Medicaid basis depreciation schedule for this facility.

Facilities which submit a depreciation schedule not solely for the Medicaid-certified long-term care facility must prepare a summary of totals which ties to Form 7. The depreciation schedule must be set up so that direct, indirect and shared assets may be easily identified. For example, for a hospital-based nursing facility, the schedule must

group hospital-only assets and nursing facility-only assets separately from each other and from shared assets. Schedules must list assets by purchase date within asset groups and departments and must be subtotaled by year of acquisition.

Section I - Schedule of Fixed Assets

Complete the Schedule of Fixed Assets and Depreciation for each category of asset. A copy of the facility's depreciation schedule must be submitted with the cost report. The depreciation schedule must balance with the totals on Form 7.

Historical Cost - Enter the actual cost of the assets. This amount must agree with the general ledger.

Medicaid Basis - Enter the historical cost of assets, limited to the cost incurred by the first owner of record on or after July 18, 1984 in accordance with the Deficit Reduction Act of 1984 plus the cost of any additions since that date.

Ending Accumulated Depreciation, Book Basis - The total accumulated depreciation per the general ledger.

Current Period Administrative and Operating Depreciation Expense - The depreciation expense for the cost report period for assets that may be depreciated three (3) to five (5) years as an administrative and operating expense in accordance with the State Plan. For facilities which share assets with another distinct part, depreciation expense must be allocated based on square footage of the entities. The expense should be reported on Form 6, Line 4-28.

Current Period Property and Equipment Depreciation Expense - The depreciation expense for the cost report period for assets that are reimbursed under the fair rental system. For facilities which share assets with another distinct part, depreciation expense must be allocated based on square footage of the entities. The expense should be reported on Form 6, Line 5-02.

Section II - Reconciliation of Cost Report Period Activity

The reconciliation of cost report period activity must reflect the assets purchased and the assets retired during the cost report period. Assets must be separated by those which are being depreciated over a 3 to 5 year period as an administrative and operating asset and those which exceed the new bed value and must be considered a renovation or major improvement.

Line 1 - Medicaid Basis, Beginning of Cost Report Period. This line must

agree with the ending Medicaid basis of capital assets on the prior period cost report on Form 7, Section II, Line 4, as adjusted by desk or field review.

Line 2 - Additions During Cost Report Period. This line must reflect the cost of capital assets purchased during the cost report period, as determined in Section V.

Line 3 - Deletions During Cost Report Period. This line must reflect the historical cost, limited to the amount allowed for Medicaid, of assets that were retired during the cost report period.

Line 4 - Transfer of assets from the category of Administrative and Operating to the Property and Equipment asset category after 3 to 5 years. The total column should be zero.

Line 5 - Medicaid Basis, End of Cost Report Period. This is the sum of Lines 1 and 2, less the amount on Line 3, plus or minus the amount on Line 4. This must agree with Section I, Medicaid Basis Total.

Section III - Assets Not Related to Patient Care

Any assets included on Form 7 that are not related to patient care must be identified in this section. State in this section names and types of entities with which the long-term care facility shares the depreciation schedule, if applicable.

Section IV - Vehicles

Complete this section for all vehicles that are included in Section I.

Section V - Current Period Asset Additions

Complete Section V by listing all asset additions during the cost report period and entering the requested information into each column. Each asset addition must be listed on a separate line. Vehicles should be included at the bottom of the list.

All facilities which do not file cost reports on a calendar year basis must submit a schedule of fixed asset additions for each calendar year using Form 7, page 2. The schedule is required after the conclusion of each calendar year. This schedule, if submitted, will be used in computing the fixed asset additions for the gross rental per diem calculation.

Column 1 Group Asset Number

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Enter the identifier for the asset from the facility's depreciation schedule, if identifying codes are used.

Column 2 Asset Description
Enter the asset description of each addition for the period which matches the description on the depreciation schedule. Additional copies of Form 7, page 2 of 2 may be submitted as needed.

Column 3 Date of Purchase
Enter the date each asset was purchased or placed in service which matches the date entered on the depreciation schedule.

Column 4 Asset Cost
Enter the cost of each asset addition for the period.

Column 5 Assets Not Used by the Medicaid Certified Portion of Long Term Care Facility
Enter the cost of all asset additions placed in service solely for use by the non-Medicaid Certified Portion of the facility. These assets will not be considered in the fair rental computation. Facilities within which all beds are long-term-care and certified for Medicaid will not use this column.

Column 6 Assets Used Solely for the Medicaid Certified Portion of Long Term Care Facility
Enter in this column, the cost of all asset additions used solely for the Medicaid-certified long-term care facility. Facilities within which all beds are long-term care and certified for Medicaid will enter the cost of all asset additions in this column.

Column 7 Shared Assets to be Allocated
Enter in this column, the cost of each asset addition which is shared between the Medicaid-certified long-term care facility and a related entity (ex. hospital or personal care home).

Column 8 Allocation Percentage
The allocation percentage for shared assets must be the proportion of the number of Medicaid-certified long-term care facility beds to total beds represented on the depreciation schedule. This allocation percentage will be used to allocate the cost of shared assets to the certified long-term care facility. This column applies only to facilities with shared assets.

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Column 9 Basis Allocated to Medicaid Certified Portion of Long-Term Care Facility
Column 7 multiplied by Column 8.

Column 10 Total Asset Additions for Medicaid Long-Term Care Facility
The sum of Columns 6 and 9. The total of Column 10 must agree with Form 7, Section II, Line 2.

FORM 8 FACILITY TRANSACTIONS WITH RELATED ORGANIZATIONS

Section I.

All providers must complete this section. If yes, complete Sections II. and III.

Section II.

Identify those costs that contain expenditures for services or supplies furnished to the facility by related organizations which have common ownership, control or interlocking directors. Such expenses are allowable at the cost to the related party to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of those costs incurred by a prudent, cost-conscious buyer. Expenses for transactions with related organizations should not exceed expenses for like items in arms' length transactions with other non-related organizations. Indicate the form number and line number to designate the location of the expense. Provide the name of the related organization, the amount of current year transactions, the cost to the related organization, and the amount of the transactions in excess of cost. The amount of transactions in excess of cost must be transferred to the appropriate line on Form 6. For example, if a facility purchased services or supplies from a related organization for $500.00 and the cost of those services or supplies to the related organization was $300.00, the excess over cost, or $200.00, must be transferred to Form 6 to offset the proper expense.

An exception to the general rule applicable to related organizations is provided in the Mississippi Medicaid State Plan. If the exception has been granted by the Division of Medicaid, please note "exception" on the applicable row in the Column titled "Amount in Excess of Cost*". Please submit a copy of the exception approval letter with the cost report.

If additional lines are needed, please submit a supplemental page using a copy of Form 8.

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Section III.

List the name of each owner in the facility and their relationship with organizations described in Section II. If additional lines are needed, please submit a supplemental page using a copy of Form 8.

FORM 9 RENTAL OF VEHICLES AND PROPERTY

Section I – Auto Lease Payments Included on Form 6, Line 4-24

List any leases pertaining to vehicles in Section I. Identify the lessor, the leased item, the terms of the lease including the amount of the monthly payment, and the percentage of personal usage. Enter the lease expense applicable to the current reporting period in Column 1. In Column 3, enter the amount applicable to the Medicaid-certified portion of the facility. Multiply Column 3 by the percentage of personal use and enter in Column 4. Use the total of Column 4 to enter an adjustment on the adjustments report for personal usage. Subtract Column 4 from Column 3 and enter in Column 5. Column totals must tie to Form 6, Line 4-24.

Section II - Rental Payments Included on Form 6, Line 5-06

List any leases pertaining to buildings. Identify the lessor, the leased item, the terms of the lease including the amount of the monthly payment, a description of the purchase option, if any, and the amount of rent applicable to the current reporting period. The total amount of the Current Period Expense column must agree with Form 6, Line 5-06, Column 5.

FORM 10 ANALYSIS OF INTEREST BEARING DEBT AND RELATED INTEREST EXPENSE

All interest bearing debt must be reported on Form 10. Each note must be listed under the columns for Note 1 - Note 11. Totals must be entered in the Totals column. If the facility had more than eleven (11) notes payable during the reporting period, please complete an additional Form 10.

Line 1 Report the lender's name. If the lender is a related party or if the note is inter-company, please enter "RP" in the cell with the lender's name.

Line 2 Balance at the beginning of the cost reporting period. The total of notes

payable (current and long-term) reported on Form 11, Column 1.

Line 3 Balance at the end of the reporting period. The total of notes payable (current and long-term) reported on Form 11, column 2.

Line 4 The current portion of interest bearing debt. The portion due within one year must be reported in this column for all interest bearing debt. The total of this line must agree with the amount on Form 11, line 24, column 2.

Line 5 The non-current portion of long-term notes payable must be reported in this column. The total must agree with Form 11, line 31, column 2.

Line 6 Describe the terms of the debt.

Line 7 Describe the purpose of the loan. For example, mortgage of building, purchase of equipment, working capital, etc.

Line 8 List the interest rate.

Line 9 Report the allowable capital interest expense for the cost reporting period. Line 9, totals column must agree with Form 6, Line 5-03, Column 1, unless interest expense is reported on Form 6, Line 5-08.

Line 10 Report the allowable non-capital or vehicle interest expense for the cost reporting period. Line 10, totals column must agree with Form 6, Line 4-33, Column 1, unless interest expense is reported on Form 6, Line 4-47.

Line 11 Report the non-allowable interest expense for the cost reporting period.

FORM 11 BALANCE SHEET

The balance sheet as of the beginning of the reporting period must be reported in Column 1 and must agree with the end of the reporting period balance sheet submitted on the previous cost report. Facilities filing an initial cost report should report in Column 1 the balance sheet as of the first day of the cost reporting period. Changes to the beginning balance sheet and prior period adjustments must be explained on Form 12. The balance sheet as of the end of the reporting period must be reported in Column 2. Hospital based facilities and state owned facilities may report the balance sheet of the

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nursing facility combined with the hospital or other non-Medicaid certified portions of the facility if a separate balance sheet is not available.

Line 1 Cash on Hand & in Banks includes all funds actually on hand or in bank accounts subject to immediate withdrawal. Facilities with accounts other than operating accounts must attach a schedule that includes the type of account, whether or not the account is interest bearing and whether or not the account is restricted.

Resident fund accounts held on behalf of the residents are not considered facility accounts and should not be included on the balance sheet.

Line 2 Accounts Receivable represent monies due the facility for services rendered to patients as of the balance sheet date. The dollar amount recorded on the schedule should represent gross accounts.

Line 3 Allowance for Uncollectible Accounts should include the estimated loss for accounts receivable that will not be collected.

Line 4 Notes Receivable includes the current portion notes other than those due from officers, owners, and/or related organizations.

Line 5 Due from Officers, Owners, and/or Related Organizations represent amounts owed the facility by officers, owners, and/or related parties as of the balance sheet date.

Line 6 Other Receivables include all current receivables which are not appropriately included on another line such as amounts due from a previous owner.

Line 7 Inter-Company Receivables represent amounts owed the facility by a home office or other nursing facility in a multi-facility operation.

Line 8 Inventory includes those goods awaiting sale or use, and excludes those long-term assets subject to depreciation.

Inventories are normally conservatively valued at the lower of "cost or market". List the method of inventory valuation in the space provided. Inventories may include dietary supplies, housekeeping and linen, general stores and others in accordance with the practice in each individual facility.

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Line 9 Prepaid Expenses represent the portion of the expenditures which will be carried forward into the next accounting period as a proper expense in another year. Examples of prepaid expenses include membership dues, insurance premiums, rent, service contracts, etc.

Line 10 Investments are normally permanent or long-term securities with value, but which are normally not available for immediate withdrawal. Investments include stock and bonds, certificates of deposit, etc. It will be assumed that all investments are for a period greater than six (6) months unless documentation is submitted with the cost report that indicates otherwise.

Line 11 Other Current Assets include all current assets which are not appropriately included on any other line of the balance sheet. These assets should be listed on the lines available on Form 11.

Line 12 Total Current Assets is the sum of Line 1 through Line 11.

Line 13 Property, Plant and Equipment must agree with the total of all assets recorded on Form 7, Section 1, Column 2. Property not related to patient care should not be offset on Form 11.

Line 14 Less Accumulated Depreciation represents a reduction of the property, plant, and equipment reported on Line 13. The amount reported in the ending column must agree with the total accumulated depreciation reported on Form 7, Section I, Column 4.

Line 15 Total Fixed Assets is the difference between Line 13 and Line 14.

Line 16 Notes Receivable-Non-current includes the non-current portion of notes other than those due from officers, owners, and related organizations.

Line 17 Due from Officers, Owners, and/or Related Organizations under Other Assets includes the non-current portion of amounts owed from officers, owners, and related organizations.

Line 18 Goodwill represents the amount paid for the nursing facility in excess of the recognized value of the other assets acquired.

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Line 19 Deposits include amounts used to secure accounts with utility companies, for workers compensation insurance or with lessors, for example. Deposits must be reported on Schedule 10.

Line 20 Other Non-current Assets represent those non-current assets which are not appropriately reported on any other line (ex. organization costs). These assets must be listed in the spaces available on Form 11.

Line 21 Total Other Assets reports the sum of amounts recorded on Lines 16 through 20.

Line 22 Total Assets represents the sum of amounts recorded on Lines 12, 15, and 21 of the balance sheet.

Line 23 Accounts Payable represent liabilities of daily transactions normally kept on open account and are limited to amounts owed to specific creditors for goods and services purchased. Exclude accounts payable owed to related parties.

Line 24 Notes Payable and Current Portion of Long-Term Debt includes obligations that are scheduled to mature within one year after the balance sheet date and the current portion of long-term debt.

Line 25 Accrued Salaries represent the salaries and wages earned by employees but not paid during the accounting period. To be recognized as an allowable expense, salaries accrued at the end of the accounting year must be paid within seventy-five (75) days of the year end.

Line 26 Accrued Payroll Taxes include non-deposited federal and state income and FICA taxes withheld. It also includes union dues and insurance withheld and the employers' liability for FICA and unemployment taxes.

Line 27 Accrued Income Taxes include any liability the facility has for federal and state income taxes.

Line 28 Inter-company Payables represent amounts owed by the facility to a home office or other nursing facility in a multi-facility operation.

Line 29 Other Current Liabilities represent any current obligations not included elsewhere on Form 11, Lines 23-28. These liabilities should be listed on

the lines provided.

Line 30 Total Current Liabilities reports the sum of amounts reported on Lines 23 through 29.

Line 31 Notes Payable - Long-Term include obligations that are scheduled to mature after one year from the balance sheet date.

Line 32 Notes Payable to Officers, Owners and/or Related Organizations represent liabilities to officers, owners, and/or related organizations.

Line 33 Total Long-Term Liabilities reports the sum of Lines 31 and 32.

Line 34 Total Liabilities is the sum of current liabilities (Line 30) and long-term liabilities (Line 33).

Lines 35-41 Capital includes lines that apply to proprietorships, partnerships, governmental facilities, limited liability companies, and corporations. Only the applicable lines should be completed.

Line 42 Total Capital is the sum of amounts reported on Lines 35 through 41.

Line 43 Total Liabilities and Capital is the sum of Total Liabilities (Line 34) and Total Capital (Line 42). Total Liabilities and Capital must agree with Total Assets (Line 22) of the balance sheet.

FORM 12 CAPITAL RECONCILIATION

Total Capital at Beginning of Period must agree with Form 11, Line 42, Column 1.

Additions to Capital - All additions to capital must be included in this section.

Line 1 Net Income for Period must agree with Form 5, Line 26, Column 1.

Line 2 Contributions to capital and the date the contribution was made must be reported on separate lines. If additional lines are needed, a schedule should be attached.

Lines 3 - 4 List any other additions to capital.

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Reductions to Capital - All reductions to capital must be included in this section.

Line 1 Dividends include those dividends declared during the cost reporting period.

Line 2 Owners' Withdrawals and the date each withdrawal was made must be reported on separate lines. If additional lines are needed, a schedule should be attached.

Lines 3 - 4 List any other reductions to capital.

Ending Capital - Total Capital at End of Reporting Period must equal the amount on Form 11, Line 42, Column 2.

FORM 13 COMPUTATION OF RETURN ON EQUITY

Equity is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) excluding net property, plant and equipment other than vehicles and liabilities associated therewith, and those assets and liabilities which are not related to the provision of patient care. Line 1 must agree with the prior period's cost report, as adjusted by desk review or financial review by the Division of Medicaid's fiscal agent. Line 2, Column 1 must agree with Form 11, Line 42, Column 2. Adjustments should be made on this form to exclude certain items from equity as specified in the Long-term Care Reimbursement Plan. The following are examples of items not included in the computation of non-property equity:

A. Property, plant and equipment, excluding vehicles

B. Debt related to property, plant and equipment, excluding vehicles

C. Liabilities related to property, plant and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance

D. Notes and loans receivable from owners or related organizations

E. Goodwill

F. Unpaid capital surplus (undistributed dividends)

G. Workmen's Compensation Self Insurance Fund

H. Unrealized capital appreciation surplus

I. Cash surrender value of life insurance policies

J. Prepaid premiums on life insurance policies

K. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period.

L. Inter-company accounts

M. Funded depreciation

N. Cash investments that are long term (more than six months)

O. Deferred tax liability attributed to non-allowable tax expense

P. Any other assets not directly related to or necessary for the provision of patient care

Q. Net capitalized loan/financing costs

R. Resident fund accounts held on behalf of the resident which were included on Form 11

Providers that are members of chain operations must also include a share of the equity of the home office, allocated based on CMS Publication 15-1 guidelines. The home office equity must be calculated using Form 18, Computation of Return on Equity for Home Office.

Facilities using a working trial balance combined for the reporting facility and another entity(s) for this cost report must complete Lines 1 - 3, Column 1 using the combined balance sheet. An adjustment must be made on Line 4 to reduce the average equity to include only the portion allocable to the Medicaid certified portion of the reporting facility. This allocation must be made based on the ratio of allowable costs from Form 6, Line 7, Column 5 to total costs of the entities reported on Form 6, Line 7, Column 1.

Line 4 Line 3, Column 4 divided by 2. For facilities using a combined balance

sheet, enter the facility percentage in column 3 (Form 6, Line 7, Column 5 divided by Form 6, Line 7, Column 1, rounded to two decimals (example: 96.41%)). Divide Form 13, Line 3, Column 4 by 2; multiply the product by the facility percentage in Line 4, Column 3.

Line 5 Total Allowable Costs from Form 6, Line 7, Column 5 divided by the number of months in the reporting period multiplied by 2.

Line 6 Enter the lesser of Line 4 or Line 5.

Line 8 Line 6 multiplied by Line 7, but not less than zero.

Line 9 Form 3, Line 5, Column A.

Line 10 Enter the number of months in the reporting period. Round to two (2) decimal places.

Line 12 Line 9 divided by Line 10 multiplied by Line 11. The annualized patient days must be based on an occupancy percentage of at least 80%.

Please note that the annualized patient days actually used for rate setting may not agree with the cost report. For rate-setting, days must be based on the number of beds certified for Medicaid at the start of the rate period and the occupancy rate of the facility during the cost report period, as reported on Form 3. (For example, Form 3, Line 7 multiplied by Form 3, Line 10 multiplied by 365 days.)

Line 13 Line 8 divided by Line 12.

FORM 14 COMPUTATION OF PER DIEM COST FOR FACILITIES WITH LESS THAN 80% OCCUPANCY

This form is required only if the total occupancy rate computed on Form 3, Line 10 is below 80%. The occupancy minimum is applied to care related and administrative and operating fixed costs. If the occupancy level is below 80%, the reported lower level of occupancy will apply to variable costs.

The allowable cost from Form 6, Column 5 must be entered in Column 1 on Form 14 for Care Related Costs and Administrative and Operating Costs. These costs must be extended into either Column 2 for variable costs or Column 3 for fixed costs. Facilities

using allocated cost lines on Form 6 must analyze those expenses to distinguish between variable and fixed costs in order to determine the correct column. Page 3 of Form 14 must be completed to compute the allowable cost per day for each cost center.

FORM 15 OWNERS, OFFICERS AND DIRECTORS COMPENSATION

A separate Form 15 must be completed for each owner or officer listed on Form 16, whether or not any compensation is claimed on the cost report. A separate Form 15 must also be completed for each director listed on Form 16 for whom compensation, excluding board of directors fees, is claimed on the cost report. Compensation is considered claimed on the cost report whether paid directly by the facility or indirectly by the facility through cost allocations. Additional copies of Form 15 should be made as needed. Compensation other than salary must be specified under other compensation. Examples of such compensation are given on Form 15. If there is not enough space for required entries under Section VI, please submit supplemental pages.

The limits and calculation guidelines for reasonableness of owners' salaries apply to salaries reported on Form 15 for owners, officers, and directors, and their immediate relatives.

FORM 16 DISCLOSURE OF OWNERSHIP

Each provider is required to complete the applicable section of this form for their type of ownership. List all having five percent (5%) or more ownership, all officers and all members of the Board during the cost report period. List the required information for each level of the ownership structure. The amount of compensation includes the amounts directly from the facility and amounts allocated from the home office and related management company. This amount must tie to Form 15, section 1, unless the only compensation is director fees and Form 15 is not required.

FORM 17 HOME OFFICE OR RELATED MANAGEMENT COMPANY COST REPORT EXPENSE ALLOCATION SUMMARY

Each provider that reports expense on Form 6, Line 4-38 or Form 6, Line 4-47 as a result of home office costs or management fees paid to a related management company must complete Form 17. Complete a separate Form 17 for each related management company and home office with cost stepped down directly or indirectly to the facility. Form(s) 17 will be accepted for the most recent Medicare cost report period, even if the

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cost report period does not match the Medicaid report of the facility. The form is to be used to report the allocation of indirectly related expenses as well as directly related expenses from the home office or related management company. Refer to cost report instructions for Forms 5 and 6 for assistance in determining revenue offsets and allowability of costs.

A copy of the working trial balance must be submitted to support each Form 17. A copy of an amortization schedule and depreciation schedule must be submitted to support costs reported on Lines 2-10 and 2-13.

Section 1 - Revenue

This section must include the total revenue of the home office or related management company. Schedule 11 must be completed for revenue included on Line 1-08.

Column 1 — This column must agree with the general ledger of the home office or the management company.

Column 2 — This column is used to show revenue offsets against expenses.

Section 2 - Expenditures

Lines 2-01 through 2-29 must be used to report the expenses for the described accounts. All expense accounts that are not listed in Section 2 must be reported on Line 2-27, Other Expense. The sum of Columns 2 and 4 must equal Column 1 in Section 2.

For related management companies and home offices with more than one Medicaid participating facility, Columns 1, 2 and 4 of Sections 1 and 2 must agree.

Column 1 — This column must agree with the general ledger of the home office or the management company.

Column 2 — This column must include adjustments made to remove expenses not related to patient care, revenues offset against expenses, and expenses directly related to **all** facilities.

Column 3 — Expenses that are directly related to the management of the facility for which the cost report is being filed must be

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reported on Column 3.

Column 4	Column 1 less Column 2 must be reported in Column 4. These are the expenses to be allocated to all facilities managed by the home office or the management company.
Column 5	Column 4 multiplied by the allocation percentage related to the facility for which the cost report is being filed must be reported in Column 5.

Cost reports with expenses on Form 17, line number 2-27, Other Expense must complete Schedule 12.

Allocation of Owners' Salaries between facilities should be calculated following these guidelines:

The paid salary must be reduced to the allowable limit for the year or portion, thereof, if payment exceeded the Medicaid limit. The allowable salary must then be allocated to the various facilities based on hours spent at each facility to total hours worked on all facilities. Total hours used in the calculation must be no more than sixty (60) and no less than forty (40). The allocation of hours to each facility may be calculated using the expense allocation factor. When the various facilities differ in classification, the limit applicable to each facility classification should be used and allocated.

Example Data:

1997 Salary Paid to Owner was $350,000.

1997 Salary Limits:	Small N.Facility	- $61,824
	Large N.Facility	- $81,410
	ICF-MR	- $40,533

Example 1:

Nursing Facility A, Small	60 Beds	30 hours worked per week
Nursing Facility B, Small	60 Beds	35 hours worked per week
Total	120 Beds	65 hours

Limit for Nursing Facility A:
Hours: 30/65 x 60 = 28
$61,824 x 28/60 = $28,851
Limit for Nursing Facility B:
Hours: 35/65 x 60 = 32
$61,824 x 32/60 = $32,973

Total: $61,824

Example 2:

Nursing Facility A, Small	60 Beds	10 hours worked per week
Nursing Facility B, Large	90 Beds	20 hours worked per week
ICF-MR Facility	75 Beds	15 hours worked per week
Non Related Work	N/A	15 hours worked per week
Totals	225 Beds	60 hours

Total Facility hours worked was 45.
Limit for Nursing Facility A, Small: $61,824 x 10/45 = $13,739

Limit for Nursing Facility B, Large: $81,410 x 20/45 = $36,182

Limit for ICF-MR: $40,533 x 15/45 = $13,511

Example 3:
Nursing Facility A, Small 60 Beds, 30 Beds Medicaid Certified 40 Hours Worked

Limit for Nursing Facility A: $61,824 x 30/60 beds = $30,912

Section 3 - Calculation of Allowable Expenditures

Line 3-01, Expenditures Directly Related to the Facility
This line must include the total expenses directly related to this facility from Form 17, Line 2-30, Column 3.

Line 3-02, Expenditures Allocated to this Facility
This line must include the total amount of this facility's allocated portion of the indirectly related expenses from Form 17, Line 2-30, Column 5.

Line 3-03, Total Allowable Expenditures
The sum of lines 3-01 and 3-02. Enter on Form 6, Line 4-38.

Section 4 - Description of Allocation Methods

This section should be used to describe the methodology used to allocate home office or related management company expenditures to this facility. If more than one method was used, define to which expense accounts each method was applied. The allocation method used must comply with Medicare guidelines as stated in the CMS Publication 15-1 beginning with Section 2150. The allocation calculation(s) must be included in Section 4 or on an attachment.

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FORM 18 COMPUTATION OF RETURN ON EQUITY FOR HOME OFFICE

Follow instructions for Form 13. However, **do not** exclude home office net property, plant and equipment and liabilities associated therewith.

SCHEDULES 1 THROUGH 15

Descriptions must be detailed enough for determination of allowability and correct classification of costs.

SCHEDULE 1

This schedule should be used to describe the revenues included on Form 5, Line 15. The amounts from the general ledger that pertain to the Medicaid Certified Portion of the Long-term Care Facility for which the cost report is being filed must be reported in Column 2. Any adjustments made as a result of a revenue offset or cost finding must be reported in Column 3. Please list the Form 6 or Medicare cost report line numbers where adjustments were entered in Column 4.

SCHEDULE 2

Direct care line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 2, Columns 2 through 5 must agree with Form 6, Line 1-18.

SCHEDULE 3

Therapy line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 3, Columns 2 through 5 must agree with Form 6, Line 2-16.

SCHEDULE 4

Care related line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 4, Columns 2 through 5 must agree with Form 6, Line 3-22.

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SCHEDULE 5

This schedule must detail miscellaneous expenses. Expenditures for $500 and under may be combined and entered on one line of the schedule with the description, "Amounts $500 and under". The totals shown for each column must agree with Form 6, Line 4-37. "Miscellaneous", "other", "various", and "etc." are not acceptable descriptions. Submit a list explaining abbreviations and acronyms used on the schedule.

SCHEDULE 6

Administrative and operating line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 6, Columns 2 through 5 must agree with Form 6, Line 4-47.

SCHEDULE 7

Property and equipment line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 7, Columns 2 through 5 must agree with Form 6, Line 5-08.

SCHEDULE 8

Describe each of the expenses reported on Form 6, Line 6-11. The total amounts must agree with Form 6, Line 6-11.

SCHEDULE 9

Enter the prior and current reporting period cost from Form 6, column 5 in columns 1 and 4, respectively. Enter prior and current reporting period total patient days from Form 3, Line 5, column A in columns 2 and 5, respectively. Calculate the cost per diem for column 3 by dividing column 1 by column 2. Divide column 4 by column 5 to calculate the cost per diem for column 6. The percent variance for column 7 is calculated by first subtracting column 3 from column 6. Then, the difference should be divided by column 3. For variances exceeding both ten percent and $1,000, enter an explanation for the increase. Please note that small and large nursing facilities are not required to complete the explanation for Line 2-15, Therapy Costs, Other.

Line 1-14, Drugs
Line 1-15, Medical Supplies

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Line 1-17, Other Supplies
Line 2-15, Therapy Costs, Other
Line 3-21, Supplies – Care Related
Line 4-08, Salaries – Other Administrative
Line 4-15, Workmen's Compensation
Line 4-22, Accounting Fees
Line 4-29, Dues
Line 4-30, Educational Seminars & Training
Line 4-32, Insurance – Professional Liability and Other
Line 4-35, Legal Fees
Line 4-36, Linen & Laundry Alternatives
Line 4-38, Management Fees & Home Office Costs
Line 4-40, Office Supplies & Subscriptions
Line 4-42, Repairs & Maintenance
Line 4-43, Taxes & Licenses
Line 4-45, Travel
Line 5-04, Property Insurance
Line 5-05, Property Taxes

SCHEDULE 10

Deposits reported on Schedule 10 must agree with Form 11, Line 19. Deposits at the beginning of the cost report period must be reported in Column 1 and ending balances must be reported in Column 2.

SCHEDULE 11

This schedule must be used to describe Other Income for the home office. Amounts must agree with Form 17, Line 1-08. The amounts from the general ledger must be reported in Column 1 and any adjustments made must be reported in Column 2.

SCHEDULE 12

This schedule must detail other home office expenses. Only amounts over $500 are required to be detailed. Amounts $500 and under should be combined and entered on one line of the schedule with the description, "Amounts $500 and under". The total amounts must agree with Form 17, Line 2-27. "Miscellaneous", "other", "various", and "etc." are not acceptable descriptions. Submit a list explaining abbreviations and acronyms used on the schedule.