

## WISCONSIN MEDICAID PROGRAM 2009 NURSING HOME COST REPORT

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

### SCHEDULE 1 – FACILITY AND PREPARER INFORMATION AND CERTIFICATION

#### SECTION A – FACILITY INFORMATION

Facility Name			Main Telephone Number		Main E-Mail Address	
Facility Street Address			City		State	Zip Code
Contact Person		Contact Telephone Number		Contact E-Mail Address		Corporate Facility Number
Cost Report Period Start Date	Cost Report Period End Date		Medicaid Provider Number	National Provider Identifier (NPI)		POP ID Number
Administrator		Chief Financial Officer		Where are the financial records of the nursing home located?		

#### SECTION B – PREPARER OF THE REPORT IF NOT AN EMPLOYEE OF THE PROVIDER

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

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

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

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

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

SIGNATURE – Original Signature of Officer or Administrator of Nursing Home			Title		Date Signed
SECTION D – For Department Use		Date Received		Medicaid District Auditor	

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

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

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Commentator's Name	Title	Date
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**SCHEDULE 3 – GENERAL INFORMATION**

1. Type of Medicaid certification (check all that apply)	<input type="checkbox"/> (01) Nursing Facility	<input type="checkbox"/> (10) ICF-MR	For Department Use - Total
2. Type of license (check all that apply)	<input type="checkbox"/> (01) Skilled Nursing	<input type="checkbox"/> (20) Developmentally Disabled	For Department Use - Total
	<input type="checkbox"/> (10) Intermediate Care	<input type="checkbox"/> (40) IMD	
3. Type of ownership (check one)	<input type="checkbox"/> (1) Proprietary	<input type="checkbox"/> (2) Voluntary Non-Profit	<input type="checkbox"/> (3) Governmental
4. County of facility			For Department Use – County Code
5. Does the facility self-fund any of the fringe benefits reported on schedule 28? If yes, provide documentation to support the amount claimed.			<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
6. Does the facility provide laundry services to residents for personal clothing?			<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
7. Are any employees of the facility covered by a union contract?			<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
8. Is the facility Medicare (Title XVIII) certified?			<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
9. Fiscal Year Beginning Month	Fiscal Year Ending Month	For Department Use – End	

<p>10. List the number of licensed beds at the beginning and end of your cost reporting period. Do not include restricted use beds.</p> <table style="width:100%; margin-left: 20px;"> <tr> <td style="width:40%;"></td> <td style="width:10%; text-align: center;"><u>DATE</u></td> <td style="width:10%; text-align: center;"><u>BEDS</u></td> <td rowspan="5" style="width:30%; text-align: center; vertical-align: middle;">For Department Use – Average Beds</td> </tr> <tr> <td style="text-align: center;"><u>Beds at Beginning of Cost Reporting Period</u></td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="text-align: center;"><u>Beds at End of Cost Reporting Period</u></td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="vertical-align: top;">If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.</td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> </tr> </table>		<u>DATE</u>	<u>BEDS</u>	For Department Use – Average Beds	<u>Beds at Beginning of Cost Reporting Period</u>			<u>Beds at End of Cost Reporting Period</u>			If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.								
	<u>DATE</u>	<u>BEDS</u>	For Department Use – Average Beds																
<u>Beds at Beginning of Cost Reporting Period</u>																			
<u>Beds at End of Cost Reporting Period</u>																			
If there has been a change in the number of licensed beds, list the date(s) of the change(s), the number of beds and briefly explain.																			

11. Has a certified audit been conducted for the cost reporting period? If yes, submit complete report copy including notes to the financial statements.	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
12. Check all related party transaction types for which expenses are reported.	<input type="checkbox"/> (1) Related party lease of building <input type="checkbox"/> (2) Compensation to owners/ family relation <input type="checkbox"/> (3) Interest expense on related party loans <input type="checkbox"/> (4) Other related party transactions
13 A. A final adjusted trial balance for the cost reporting period, including a reconciliation of the trial balance to the cost report must be submitted with this cost report. Have copies been made and included with this cost report?	<input type="checkbox"/> Yes <input type="checkbox"/> No
13 B. Asset depreciation schedules detailing amounts reported on Schedule 34 – Depreciation Expenses must be submitted. Have copies been made and included with this cost report?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

A. Name	B. License Number	C. Single-Bed Rooms	D. Beds in Multiple-Bed Rooms	E. Total Licensed Beds
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. TOTAL .....	_____	_____	_____	_____

### SCHEDULE 4 – MAJOR REVENUE GENERATING ACTIVITIES

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

**SCHEDULE 5 – BUILDING SQUARE FOOTAGE**

**SECTION A – GENERAL INFORMATION**

	Wing A	Wing B	Wing C	Wing D
Name or description of building or wing . . . . .	_____	_____	_____	_____
Year construction was functionally completed on building or wing . . . . .	_____	_____	_____	_____
Total Square footage of building or wing . . . . .	_____	_____	_____	_____

**SECTION B – NURSING HOME SERVICE AREAS**

	sq.ft.	sq.ft.	sq.ft.	sq.ft.
1. Nuns or other employees' housing . . . . .	_____	_____	_____	_____
2. Employees' unique fringe benefit areas . . . . .	_____	_____	_____	_____
3. Dietary (kitchen, food preparation & storage, dish washing, kitchen cleanup) . . . . .	_____	_____	_____	_____
4. Plant equipment (furnace/boiler room, electrical, water, similar plant equip.) . . . . .	_____	_____	_____	_____
5. Laundry (washing/drying rooms, sorting/folding rooms, central linen storage) . . . . .	_____	_____	_____	_____
6. Administration (general/accounting offices, reception areas, meeting rooms) . . . . .	_____	_____	_____	_____
7. Laboratory and radiology . . . . .	_____	_____	_____	_____
8. Pharmacy . . . . .	_____	_____	_____	_____
9. Physical therapy . . . . .	_____	_____	_____	_____
10. Occupational therapy . . . . .	_____	_____	_____	_____
11. Other therapies . . . . .	_____	_____	_____	_____
12. Beauty and barber shops . . . . .	_____	_____	_____	_____
13. Gift shop, canteen, snack shop . . . . .	_____	_____	_____	_____
14. Patient areas (rooms, bathrooms, halls, nurse desk/office, dayrooms, rec.) . . . . .	_____	_____	_____	_____

**SECTION C – RENTED AND OTHER MAJOR REVENUE ACTIVITY AREAS (SEE SCHEDULE 4). IDENTIFY EACH ACTIVITY.**

15. Hospital direct patient service areas . . . . .	_____	_____	_____	_____
16. _____	_____	_____	_____	_____
17. _____	_____	_____	_____	_____
18. _____	_____	_____	_____	_____

**SECTION D – OTHER AREAS**

19. Major idle or closed areas . . . . .	_____	_____	_____	_____
20. Residual unidentified square footage (Total area less lines 1 through 19) . . . . .	_____	_____	_____	_____

Describe general purpose or use of line 20 square footage:

FOR DEPT. USE – NET SQ. FT.

**SCHEDULE 6 – TOTAL PATIENT DAYS**

**SECTION A – INHOUSE PATIENT DAYS**

**LEVEL OF CARE (LOC)**

	<u>NON DD</u>	<u>DD 3</u>	<u>DD 2</u>	<u>DD 1B</u>	<u>DD 1A</u>	<u>TOTAL</u>
1a. Medicaid (T-19) . . . . .	_____	_____	_____	_____	_____	_____
1b. FDD Medicaid (T-19) . . . . .	_____	_____	_____	_____	_____	_____
1c. Family Care (T-19) . . . . .	_____	_____	_____	_____	_____	_____
1d. Other Partnership Programs (T-19) . .	_____	_____	_____	_____	_____	_____
1e. Hospice (T-19). . . . .	_____	_____	_____	_____	_____	_____
1f. Ventilator (T-19). . . . .	_____	_____	_____	_____	_____	_____
2. Medicare (T-18) . . . . .	_____	_____	_____	_____	_____	_____
3. Private pay & Insurance . . . . .	_____	_____	_____	_____	_____	_____
4. Other - Specify. . . . .	_____	_____	_____	_____	_____	_____
5. TOTAL INHOUSE PATIENT DAYS. . . .	_____	_____	_____	_____	_____	_____

**SECTION B – BEDHOLD DAYS**

	<u>NON DD</u>	<u>DD 3</u>	<u>DD 2</u>	<u>DD 1B</u>	<u>DD 1A</u>	<u>TOTAL</u>
6a. Medicaid (T-19) . . . . .	_____	_____	_____	_____	_____	_____
6b. FDD Medicaid (T-19) . . . . .	_____	_____	_____	_____	_____	_____
6c. Family Care & Partnership (T-19) . . . .	_____	_____	_____	_____	_____	_____
7. All Other . . . . .	_____	_____	_____	_____	_____	_____
8. TOTAL BEDHOLD DAYS . . . . .	_____	_____	_____	_____	_____	_____

**SECTION C – TOTAL PATIENT DAYS**

	<u>NON DD</u>	<u>DD 3</u>	<u>DD 2</u>	<u>DD 1B</u>	<u>DD 1A</u>	<u>TOTAL</u>
9. TOTAL DAYS (lines 5 + 8) . . . . .	_____	_____	_____	_____	_____	_____

**SCHEDULE 7 – NO LONGER USED**

Information is now on Schedule 6

**SCHEDULE 8 – TOTAL PATIENT DAYS BY MONTH**

	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	TOTAL
1. MONTH . . . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
2. Days in Month. . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
3. Licensed Beds for Bedhold Testing. . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. Occupancy Test - Enter Lower of: Row 2 X Row 3 X .94 Row 2 X (Row 3 – 9)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
5. Inhouse patient days. . . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
6. Bedhold days . . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
7. TOTAL DAYS . . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

Explanation for why Licensed Beds for Bedhold Testing are less than Licensed Beds \_\_\_\_\_

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

**SCHEDULE 9A – HOSPICE PATIENT DAYS – NO LONGER USED**

Information is now on Schedule 6

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

Information is now on Schedule 6

**SCHEDULE 10 – BALANCE SHEET**

ASSETS		Begin Date	End Date
<b>CURRENT ASSETS</b>	Cash on hand and in bank . . . . .	\$	\$
	Temporary investments . . . . .		
	Resident accounts receivable . . . . .		
	Other accounts receivable . . . . .		
	Due from related parties . . . . .		
	Notes receivable . . . . .		
	Accrued interest receivable . . . . .		
	Inventories . . . . .		
	Prepaid expenses . . . . .		
	Resident funds held in trust . . . . .		
Other current assets, list below:			
<b>TOTAL CURRENT ASSETS . . . . .</b>	<b>\$</b>	<b>\$</b>	
<b>PROPERTY, PLANT, EQUIP.</b>	Land . . . . .	\$	\$
	Land improvements . . . . .		
	Buildings . . . . .		
	Leasehold improvements . . . . .		
	Fixed equipment . . . . .		
	Moveable equipment . . . . .		
	Transportation equipment . . . . .		
	Other . . . . .		
	Less: accumulated depreciation . . . . .	( )	( )
	<b>TOTAL PROPERTY, PLANT, EQUIPMENT</b>	<b>\$</b>	<b>\$</b>
<b>OTHER</b>	Long term investments . . . . .	\$	\$
	Other Assets, list below:		
<b>TOTAL OTHER ASSETS . . . . .</b>	<b>\$</b>	<b>\$</b>	
<b>TOTAL ASSETS . . . . .</b>	<b>\$</b>	<b>\$</b>	

LIABILITIES AND OWNERS' EQUITY		Begin Date	End Date
<b>CURRENT LIABILITIES</b>	Notes and loans payable, list below:		
		\$	\$
	Due to related parties . . . . .		
	Accounts payable . . . . .		
	Accrued salaries . . . . .		
	Other accrued expenses . . . . .		
	Resident trust funds payable . . . . .		
	Other current liabilities . . . . .		
<b>TOTAL CURRENT LIABILITIES . . . . .</b>	<b>\$</b>	<b>\$</b>	
<b>LONG TERM LIAB.</b>	Notes and loans payable, list below:		
		\$	\$
Other long term liabilities . . . . .			
<b>TOTAL LONG TERM LIABILITIES . . . . .</b>	<b>\$</b>	<b>\$</b>	
<b>OWNER EQUITY</b>	<b>OWNERS' EQUITY, list below:</b>		
		\$	\$
<b>TOTAL OWNER'S EQUITY . . . . .</b>	<b>\$</b>	<b>\$</b>	
<b>TOTAL LIABILITIES AND EQUITY . . . . .</b>	<b>\$</b>	<b>\$</b>	

**SCHEDULE 10A – SUMMARY OF CHANGES IN OWNERS’ EQUITY**

1.	Beginning Owners’ Equity (from schedule 10) .....		\$ _____
2.	Add	Net income (from schedule 11, line 21) ..... \$ _____ Owners’ capital contribution ..... _____ County appropriation ..... _____ Net decrease in accrued vacation, holiday and sick time. . . _____ Other, Specify: _____ Other, Specify: _____ Total additions ..... _____	
3.	Deduct	Net loss (from schedule 11, line 21) ..... \$ ( _____ ) Dividends and withdrawals ..... ( _____ ) Net increase in accrued vacation, holiday and sick time. . . ( _____ ) Other, Specify: _____ ( _____ ) Other, Specify: _____ ( _____ ) Total deductions ..... ( _____ )	
4.	ENDING OWNERS’ EQUITY (schedule 10) .....		\$ _____

**SCHEDULE 11 – SUMMARY OF REVENUES AND EXPENSES**

**SECTION A – SUMMARY OF REVENUE**

1. Daily patient service revenue . . . . .	schedule 14, line 12	\$ _____
2. Service fees . . . . .	schedule 15, line 14A	_____
3. Rent from outside medical providers . . . . .	schedule 15, line 14B	_____
4. Other . . . . .	schedule 15, line 14C	_____
5. Dietary revenues . . . . .	schedule 16, line 5A	_____
6. Miscellaneous services and materials revenue . . . . .	schedule 16, line 17	_____
7. Rental revenues . . . . .	schedule 17, line 21A	_____
8. Revenues from other major activities . . . . .	schedule 17, line 37	_____
9. Sales to related organizations . . . . .	schedule 18, line 41	_____
10. Investment revenue . . . . .	schedule 18, line 45	_____
11. Gains (Losses) on disposal of assets . . . . .	schedule 18, line 53	_____
12. Grants for government-subsidized employees . . . . .	schedule 18, line 57	_____
13. Grants, contributions, donations . . . . .	schedule 18, line 62	_____
14. Other revenue . . . . .	schedule 18, line 69	_____
15. Subtract: deductions from revenues . . . . .	schedule 19, line 9	( _____ )
16. NET REVENUES . . . . .		\$ _____

**SECTION B – SUMMARY OF NET INCOME OR LOSS**

17. Subtract: total expenses . . . . .	schedule 12, line 39	\$ ( _____ )
18. Add or subtract the amount to adjust related party transactions to cost . . . . .	schedule 42, line 15	_____
19. NET INCOME OR LOSS BEFORE INCOME TAXES . . . . .		\$ _____
20. Subtract income taxes – optional . . . . .	schedule 38, line 6	( _____ )
21. NET INCOME OR LOSS AFTER INCOME TAXES . . . . .		\$ _____

**SCHEDULE 12 – SUMMARY OF TOTAL EXPENSES**

<u>Cost Center</u>	<u>Reference</u>	<u>Expense</u>	<u>Cost Center</u>	<u>Reference</u>	<u>Expense</u>
1. Daily patient service expense . . . . .	S20, L16	\$ _____	21. Transportation . . . . .	S25, L19	_____
2. Laboratory . . . . .	S21, L15	_____	22. Administrative service expense . . . . .	S26, L12	_____
3. Radiology . . . . .	S21, L15	_____	Other cost centers, Specify:		
4. Pharmacy . . . . .	S21, L15	_____	23. _____	S27, L15	_____
5. Physical Therapy . . . . .	S22, L15	_____	24. _____	S27, L15	_____
6. Occupational Therapy . . . . .	S22, L15	_____	25. _____	S27, L15	_____
7. Physician . . . . .	S22, L15	_____	26. _____	S27, L15	_____
8. Social Services . . . . .	S23, L15	_____	27. _____	S27, L15	_____
9. Recreational Activities . . . . .	S23, L15	_____	UNASSIGNED EXPENSES		
10. Religious Services . . . . .	S23, L15	_____	28. Employee fringe benefit expense . . . . .	S28, L17	_____
11. Speech . . . . .	S24, L15	_____	29. Heating fuel and utility expense . . . . .	S29, L10	_____
12. Dental . . . . .	S24, L15	_____	30. Interest on operating working capital loans	S30, L6	_____
13. Psychotherapy . . . . .	S24, L15	_____	31. Insurance expense . . . . .	S31, L9	_____
14. Respiratory Care . . . . .	S24, L15	_____	32. Amortization expense . . . . .	S32, L5	_____
15. Volunteer coordinator, ward clerks, other . .	S24A, L15	_____	33. Interest on plant asset loans . . . . .	S33, L8	_____
16. Dietary . . . . .	S25, L19	_____	34. Depreciation expense . . . . .	S34, L20	_____
17. Plant operation and maintenance . . . . .	S25, L19	_____	35. Expense on operating and non-cap. leases	S35, L9	_____
18. Housekeeping . . . . .	S25, L19	_____	36. Expense on capitalized leases . . . . .	S36, L3	_____
19. Laundry and linen . . . . .	S25, L19	_____	37. Property tax expense . . . . .	S37, L8	_____
20. Security . . . . .	S25, L19	_____	38. Other non-salary expense . . . . .	S39, L4	_____
			39. TOTAL EXPENSES FOR REPORT PERIOD (Sum 1-38)		\$ _____
			(To schedule 11, line 17)		

**SCHEDULE 13 – SUMMARY OF SALARY AND WAGE EXPENSES**

<b>Cost Center and Schedule</b>	<b>Total Salary and Wage Expense (Line 1 or 5)</b>	<b>Cost Center and Schedule</b>	<b>Total Salary and Wage Expense (Line 1 or 5)</b>
Daily patient service . . . . .	20 \$ _____	Plant operation / maintenance .	25 _____
Laboratory . . . . .	21 _____	Housekeeping . . . . .	25 _____
Radiology . . . . .	21 _____	Laundry and linen . . . . .	25 _____
Pharmacy . . . . .	21 _____	Security . . . . .	25 _____
Physical therapy . . . . .	22 _____	Transportation . . . . .	25 _____
Occupational therapy . . . . .	22 _____	Administrative service . . . . .	26 _____
Physician . . . . .	22 _____	Nurse aide training . . . . .	27 _____
Social services . . . . .	23 _____	Beauty and barber . . . . .	27 _____
Recreational activities . . . . .	23 _____	Other, Specify: . . . . .	27 _____
Religious services . . . . .	23 _____	_____	_____
Speech . . . . .	24 _____	_____	_____
Dental . . . . .	24 _____	_____	_____
Psychotherapy . . . . .	24 _____	TOTAL SALARY AND WAGE EXPENSE	\$ _____
Respiratory care . . . . .	24 _____		
Volunteer coordinator . . . . .	24A _____		
Ward clerks . . . . .	24A _____		
Other . . . . .	24A _____		
Dietary . . . . .	25 _____		

**For Department Use**

**SCHEDULE 14 – DAILY PATIENT SERVICE REVENUES**

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

<b>SECTION A – DAILY RATE CHARGES</b>	<b>Revenue</b>
1. Medicare .....	\$ _____
2. Medicaid .....	_____
3. Private Pay .....	_____
4. Other .....	_____

<b>SECTION B – BEDHOLD CHARGES</b>	
5. Medicaid .....	_____
6. Private Pay .....	_____
7. Other .....	_____

<b>SECTION C – MEDICAL SUPPLIES</b>	
8. Inpatient .....	_____
9. Outpatient .....	_____
10. Other, Specify: _____	_____
11. OTC drugs .....	_____

<b>SECTION D – TOTAL</b>	
12. TOTAL DAILY PATIENT SERVICE REVENUE .....	\$ _____

Do Medicaid revenues on Line 2 include retroactive Medicaid rate adjustments? (Check one)

Yes, all significant retroactive Medicaid rate adjustments are included.  
 No, substantial retroactive Medicaid rate adjustments are NOT included.  
 Estimate, an estimate of retroactive Medicaid rate adjustments IS included  
 Other, Specify \_\_\_\_\_

### SCHEDULE 15 – SPECIAL SERVICE REVENUES

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

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

**SECTION A – SERVICE REVENUES**

	A. Service Fee Charges	B. Rent from Outside Medical Providers	C. From Other Sources	Describe Other
1. Laboratory .....	\$ _____	\$ _____	\$ _____	_____
2. Radiology .....	_____	_____	_____	_____
3. Pharmacy .....	_____	_____	_____	_____
4. Physical therapy .....	_____	_____	_____	_____
5. Speech/hearing therapy .....	_____	_____	_____	_____
6. Occupational therapy .....	_____	_____	_____	_____
7. Physician care .....	_____	_____	_____	_____
8. Psychotherapy .....	_____	_____	_____	_____
9. Respiratory therapy .....	_____	_____	_____	_____
10. Social services .....	_____	_____	_____	_____
11. Recreational activities .....	_____	_____	_____	_____
12. Special duty nursing .....	_____	_____	_____	_____
13. Other, Specify: _____	_____	_____	_____	_____
14. TOTAL SPECIAL SERVICE REVENUE . .	\$ _____	\$ _____	\$ _____	

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

**SECTION B – THERAPY REVENUES**

15. Are physical, occupational, or speech therapy services provided by staff, assistants, contractors, or consultants IN SPACE AT YOUR FACILITY?  Yes  No
16. Total gross revenues for physical, occupational, and speech therapy services provided at your facility during the cost report period . . . . . \$ \_\_\_\_\_  
 Provide the total regardless of who provides the services, who bills for the services, or who receives the services (residents vs. non-residents).
17. From section A, total the amounts in columns A, B and C on lines 4, 5 and 6 (sum 4A , 4B, 4C, 5A, 5B, 5C, 6A, 6B, 6C) . . . . . \$ \_\_\_\_\_
18. If there is any variance between the totals reported on lines 16 and 17, explain. \_\_\_\_\_
- 
19. Are therapy services provided to individuals in addition to your nursing home residents?  Yes  No **If yes, amount of revenue** \$ \_\_\_\_\_
20. Does your facility or related organization bill Medicare Part B for therapy services at your facility?  Yes  No **If yes, amount of revenue** \$ \_\_\_\_\_
21. Did you charge rent to a rehabilitation agency or independent contractor?  Yes  No **If yes, amount of revenue** \$ \_\_\_\_\_

**SCHEDULE 16 – OTHER REVENUES**

**SECTION A – CAFETERIA AND DIETARY REVENUE**

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

**SECTION B – MISCELLANEOUS SERVICES AND MATERIALS**

**Expenses Directly Ascribable To Or Identifiable With Revenue**

	<b>Revenue</b>	<b>A. Related Direct Expense (if known)</b>	<b>B. Cost Center where expense included</b>	<b>C. Schedule Number</b>	<b>D. Line Number</b>
6a. Personal laundry services for private pay residents . . . . .	\$ _____	\$ _____	_____	_____	_____
6b. Other laundry serv., Specify: _____	_____	\$ _____	_____	_____	_____
7. Dry cleaning services . . . . .	_____	\$ _____	_____	_____	_____
8. Sale of personal hygiene items . . . . .	_____	\$ _____	_____	_____	_____
9. Transportation . . . . .	_____	\$ _____	_____	_____	_____
10. Beauty and barber shops . . . . .	_____	\$ _____	_____	_____	_____
11. Gift shop . . . . .	_____	\$ _____	_____	_____	_____
12. Canteen and snack counter . . . . .	_____	\$ _____	_____	_____	_____
13. Vending machines . . . . .	_____	\$ _____	_____	_____	_____
14. Sale of clothing . . . . .	_____	\$ _____	_____	_____	_____
15. Television and radio . . . . .	_____	\$ _____	_____	_____	_____
16. Telephone and telegraph . . . . .	_____	\$ _____	_____	_____	_____
17. TOTAL MISCELLANEOUS SERVICES AND MATERIALS	\$ _____				

**SCHEDULE 17 – OTHER REVENUES**

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

<b>SECTION C – RENTAL REVENUE</b>	<u>Revenue</u>	<u>Property Rented</u>	<u>Square Feet Rented</u>	<u>Services Provided</u>
18. Equipment rental . . . . .	\$ _____	_____	_____	_____
19. Rental of nursing home space . . . . .	_____	_____	_____	_____
20. Rental of non-nursing home space . . . . .	_____	_____	_____	_____
21. Parking . . . . .	_____	_____	_____	_____
21a.TOTAL RENTAL REVENUES . . . . .	<u>\$ _____</u>			

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

**SCHEDULE 18 – OTHER REVENUES**

<b>SECTION E – SALES TO RELATED ORGANIZATIONS</b>		<b>Revenue</b>	<b>SECTION H – GRANTS FOR GOVT. SUBSIDIZED EMP.</b>		<b>Revenue</b>
38.	_____	\$ _____	54.	_____	\$ _____
39.	_____	_____	55.	_____	_____
40.	_____	_____	56.	_____	_____
41.	TOTAL SALES TO RELATED ORGANIZATIONS . . . . .	\$ _____	57.	TOTAL GRANTS FOR GOVT. SUBS. EMPLOYEES . .	\$ _____

<b>SECTION F – INTEREST AND INVESTMENT REVENUE</b>		<b>Revenue</b>	<b>SECTION I – GRANTS, CONTRIBUTIONS, DONATIONS</b>		<b>Revenue</b>
42.	Revenue from invested gift/grant funds not commingled with other funds . . . . .	\$ _____	58.	Donated services (see 64 below) . . . . .	\$ _____
43.	Revenue from invested funds used for current cash needs	_____	59.	Donated supplies and materials (see 64 below) . . . . .	_____
44.	Other revenue from invested funds . . . . .	_____	60.	General donations and contributions . . . . .	_____
45.	TOTAL INVESTMENT REVENUE . . . . .	\$ _____	61.	Donor restricted funds used for current operations (see 64 below) . . . . .	_____
46.	If total investment revenue exceeds \$6,000, describe major investments (type, invested amount, purpose if any) _____ _____ _____		62.	TOTAL GRANTS, CONTRIBUTIONS, DONATIONS . .	\$ _____
			63.	Donor restricted funds for plant asset purchase or debt retirement (do not transfer to schedule 11) . . . . .	\$ _____
			64.	For lines 58, 59 and 61, attach a sheet describing the items, amount of related expense reported in this cost report, and where the expense is reported.	

<b>SECTION G – GAINS (LOSSES) DISPOSAL OF ASSETS</b>		<b>Gain (Loss)</b>	<b>SECTION J – OTHER REVENUES</b>		<b>Revenue</b>
47.	Land . . . . .	\$ _____	65.	_____	\$ _____
48.	Land improvements, buildings, fixed equipment . . . . .	_____	66.	_____	_____
49.	Moveable equipment . . . . .	_____	67.	_____	_____
50.	Transportation vehicles . . . . .	_____	68.	_____	_____
51.	Investment securities . . . . .	_____	69.	TOTAL OTHER REVENUES . . . . .	\$ _____
52.	Other assets, Specify: _____	_____			
53.	TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS . . .	\$ _____			

**SCHEDULE 19 – DEDUCTIONS FROM REVENUES**

**INSTRUCTIONS:** This schedule outlines deductions from revenue for amounts reported on schedules 14 and 15. Deductions from revenue are amounts which should be subtracted from revenues to determine net realized revenues. Such deductions are not expenses.

**SECTION A – MISCELLANEOUS**

**Revenue Deductions**

- 1. Bad debts ..... \$ \_\_\_\_\_
- 2. Charity Service ..... \_\_\_\_\_

**SECTION B – DAILY SERVICE AND SPECIAL SERVICE CONTRACTUAL ADJUSTMENTS**

- 3. Medicare
  - Physical therapy ..... \$ \_\_\_\_\_
  - Speech therapy ..... \_\_\_\_\_
  - Occupational therapy ..... \_\_\_\_\_
  - All other ..... \_\_\_\_\_
- 4. Medicaid
  - Physical therapy ..... \_\_\_\_\_
  - Speech therapy ..... \_\_\_\_\_
  - Occupational therapy ..... \_\_\_\_\_
  - All other ..... \_\_\_\_\_
- 5. Other
  - Physical therapy ..... \_\_\_\_\_
  - Speech therapy ..... \_\_\_\_\_
  - Occupational therapy ..... \_\_\_\_\_
  - All other ..... \_\_\_\_\_

**SECTION C – OTHER DEDUCTIONS FROM REVENUE**

- 6. \_\_\_\_\_ \$ \_\_\_\_\_
- 7. \_\_\_\_\_ \_\_\_\_\_
- 8. \_\_\_\_\_ \_\_\_\_\_

**SECTION D – TOTAL**

- 9. TOTAL DEDUCTIONS FROM REVENUE (Sum 1-9) ..... \$ \_\_\_\_\_

**SCHEDULE 20 – DAILY PATIENT SERVICE EXPENSES**

<u>SALARIES, WAGES, PURCHASED SERV.</u>	<u>A. Registered Nurses</u>	<u>B. Licensed Practical Nurses</u>	<u>C. Nurse Aides and Assistants</u>	<u>D. Resident Living Staff</u>	<u>E. Total Expense/Hrs. (sum A – D)</u>
1. TOTAL SALARY AND WAGE EXPENSE	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. TOTAL SALARY AND WAGE HOURS	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.
3. EXPENSE FOR PURCHASED SERVICES	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Lines 4 – 7 are no longer used					
<b><u>NURSING AND INCONTINENCY SUPPLIES</u></b>					
8. Purchased laundry service for diapers/underpads, Specify vendor: _____					\$ _____
9. Diapers, underpads, and other paper and cloth incontinency supplies . . . . .					_____
10. Catheter and bladder irrigation supplies and other incontinency apparatuses . . . . .					_____
OXYGEN					
11. Oxygen, or daily rental of oxygen concentrators, all other oxygen supplies and cylinder rental . . . . .					_____
OTHER					
12. Other medical supplies, personal comfort supplies, and minor medical equipment . . . . .					_____
13. Nonbillable over the counter (OTC) drugs for all residents (report OTC drugs that are billable on schedule 21, line 11) . . . . .					_____
14. _____					_____
15. _____					_____
16. TOTAL DAILY PATIENT SERVICE EXPENSE (Sum 1,3, 8-15) . . . . .					\$ _____

**SCHEDULE 21 – SPECIAL SERVICE EXPENSES**

SECTION A – SALARY AND WAGES	TYPE OF SERVICE		
	A. Laboratory	B. Radiology	C. Pharmacy
1. Expense for hours worked – Billable . . . . .	\$ _____	\$ _____	\$ _____
2. Number of hours worked – Billable . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
3. Expense for hours worked – Non-billable . . . . .	\$ -0-	\$ -0-	\$ _____
4. Number of hours worked – Non-billable . . . . .	-0- hrs.	-0- hrs.	_____ hrs.
5. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$ _____	\$ _____	\$ _____
<b>SECTION B – PURCHASED SERVICES</b>			
6. Expense for purchased service – Billable . . . . .	\$ _____	\$ _____	\$ _____
7. Number of hours of purchased service – Billable (optional) . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
8. Expense for purchased service – Non-billable . . . . .	\$ -0-	\$ -0-	\$ _____
9. Number of hours of purchased service – Non-billable (optional) . . . . .	-0- hrs.	-0- hrs.	_____ hrs.
<b>SECTION C – SUPPLY AND OTHER EXPENSE</b>			
10. Pharmacy – legend drugs - Billable . . . . .	\$ -0-	\$ -0-	\$ _____
11. Pharmacy – over the counter drugs - Billable . . . . .	-0-	-0-	_____
12. Supply and Other . . . . .	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
<b>SECTION D – TOTAL</b>			
15. TOTAL EXPENSES (Sum 5,6,8,10-14) . . . . .	\$ _____	\$ _____	\$ _____
16. TOTAL HOURS (Sum 2,4,7,9) . . . . .	_____ hrs.	_____ hrs.	_____ hrs.

**SCHEDULE 22 – SPECIAL SERVICE EXPENSES**

SECTION A – SALARY AND WAGES	TYPE OF SERVICE		
	A. Physical Therapy	B. Occupational Therapy	C. Physician
1. Expense for hours worked – Billable . . . . .	\$ _____	\$ _____	\$ _____
2. Number of hours worked – Billable . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
3. Expense for hours worked – Non-billable . . . . .	\$ _____	\$ _____	\$ _____
4. Number of hours worked – Non-billable . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
5. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$ _____	\$ _____	\$ _____
<b>SECTION B – PURCHASED SERVICES</b>			
6. Expense for purchased service – Billable . . . . .	\$ _____	\$ _____	\$ _____
7. Number of hours of purchased service – Billable (optional) . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
8. Expense for purchased service – Non-billable . . . . .	\$ _____	\$ _____	\$ _____
9. Number of hours of purchased service – Non-billable (optional) . . . . .	_____ hrs.	_____ hrs.	_____ hrs.
<b>SECTION C – SUPPLY AND OTHER EXPENSE</b>			
10. _____	\$ _____	\$ _____	\$ _____
11. _____	_____	_____	_____
12. _____	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
<b>SECTION D – TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$ _____	\$ _____	\$ _____
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	_____ hrs.	_____ hrs.	_____ hrs.

**SCHEDULE 23 – SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE		
	A. Social Services	B. Recreational Activities	C. Religious Services
<b>SECTION A – SALARY AND WAGES</b>			
1. Expense for hours worked – Billable . . . . .	\$ -0-	\$ -0-	\$ -0-
2. Number of hours worked – Billable . . . . .	-0- hrs.	-0- hrs.	-0- hrs.
3. Expense for hours worked – Non-billable . . . . .	\$	\$	\$
4. Number of hours worked – Non-billable . . . . .	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$	\$	\$
<b>SECTION B – PURCHASED SERVICES</b>			
6. Expense for purchased service – Billable . . . . .	\$ -0-	\$ -0-	\$ -0-
7. Number of hours of purchased service – Billable (optional) . . . . .	-0- hrs.	-0- hrs.	-0- hrs.
8. Expense for purchased service – Non-billable . . . . .	\$	\$	\$
9. Number of hours of purchased service – Non-billable (optional) . . . . .	hrs.	hrs.	hrs.
<b>SECTION C – SUPPLY AND OTHER EXPENSE</b>			
10. _____	\$	\$	\$
11. _____			
12. _____			
13. _____			
14. _____			
<b>SECTION D - TOTAL</b>			
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$	\$	\$
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	hrs.	hrs.	hrs.

**SCHEDULE 24 – OTHER TYPES OF SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE			
	A. Speech	B. Dental	C. Psychotherapy	D. Respiratory Care
<b>SECTION A – SALARY AND WAGES</b>				
1. Expense for hours worked – Billable . . . . .	\$	\$	\$	\$
2. Number of hours worked – Billable . . . . .	hrs.	hrs.	hrs.	hrs.
3. Expense for hours worked – Non-billable . . . . .	\$	\$	\$	\$
4. Number of hours worked – Non-billable . . . . .	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$	\$	\$	\$
<b>SECTION B – PURCHASED SERVICE</b>				
6. Expense for purchased service – Billable . . . . .	\$	\$	\$	\$
7. Number of hours of purchased service – Billable (optional) . . . . .	hrs.	hrs.	hrs.	hrs.
8. Expense for purchased service – Non-billable . . . . .	\$	\$	\$	\$
9. Number of hours of purchased service – Non-billable (optional) . . . . .	hrs.	hrs.	hrs.	hrs.
<b>SECTION C – SUPPLY AND OTHER EXPENSE</b>				
10. _____	\$	\$	\$	\$
11. _____				
12. _____				
13. _____				
14. _____				
<b>SECTION D - TOTAL</b>				
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$	\$	\$	\$
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	hrs.	hrs.	hrs.	hrs.

**SCHEDULE 24A – OTHER TYPES OF SPECIAL SERVICE EXPENSES**

	TYPE OF SERVICE			
	A. Volunteer Coord.	B. Ward Clerks	C.	D.
<b>SECTION A – SALARY AND WAGES</b>				
1. Expense for hours worked – Billable . . . . .	\$ -0-	\$ -0-	\$	\$
2. Number of hours worked – Billable . . . . .	-0- hrs.	-0- hrs.	hrs.	hrs.
3. Expense for hours worked – Non-billable . . . . .	\$	\$	\$	\$
4. Number of hours worked – Non-billable . . . . .	hrs.	hrs.	hrs.	hrs.
5. TOTAL SALARY AND WAGE EXPENSE . . . . .	\$	\$	\$	\$
<b>SECTION B – PURCHASED SERVICE</b>				
6. Expense for purchased service – Billable . . . . .	\$ -0-	\$ -0-	\$	\$
7. Number of hours of purchased service – Billable (optional) . . . . .	-0- hrs.	-0- hrs.	hrs.	hrs.
8. Expense for purchased service – Non-billable . . . . .	\$	\$	\$	\$
9. Number of hours of purchased service – Non-billable (optional) . . . . .	hrs.	hrs.	hrs.	hrs.
<b>SECTION C – SUPPLY AND OTHER EXPENSE</b>				
10. _____	\$	\$	\$	\$
11. _____				
12. _____				
13. _____				
14. _____				
<b>SECTION D - TOTAL</b>				
15. TOTAL EXPENSES (Sum 5, 6, 8, 10-14) . . . . .	\$	\$	\$	\$
16. TOTAL HOURS (Sum 2, 4, 7, 9) . . . . .	hrs.	hrs.	hrs.	hrs.

**SCHEDULE 25 – GENERAL SERVICE EXPENSES**

<b>SECTION A – SALARIES AND WAGES</b>	<b>A. Dietary</b>	<b>B.Plant Op./Maint.</b>	<b>C. Housekeeping</b>	<b>D. Laundry / Linen</b>	<b>E. Security</b>	<b>F. Transportation</b>
1. TOTAL SALARY AND WAGE EXPENSE	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. NUMBER OF HOURS WORKED	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.
Lines 3-5 are no longer used						
<b>SECTION B – DIETICIAN CONSULTANT</b>						
6. Dietician consultant expense	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
Line 7 is no longer used						
<b>SECTION C – OUTSIDE SERVICE</b>						
8. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
9. _____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____
<b>SECTION D – FOR DEPARTMENT USE</b>						
12. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>SECTION E – SUPPLY AND OTHER EXPENSE</b>						
13. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
14. _____	_____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____	_____
16. _____	_____	_____	_____	_____	_____	_____
17. _____	_____	_____	_____	_____	_____	_____
<b>SECTION F – FOR DEPARTMENT USE</b>						
18. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
<b>SECTION G – TOTAL</b>						
19. TOTAL EXPENSES (Sum 1, 6, 8-11, 13-17)	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**SCHEDULE 25A – ALLOCATION OF DIETARY AND PLANT OPERATION AND MAINTENANCE EXPENSES**

**SECTION A – ALLOCAITON OF DIETARY EXPENSES**

1. Total dietary expenses (from schedule 25, line 19) . . . . .	\$ _____
2. Deduct expense for food products provided to employees without charge (to line 9 below) . . . . .	(\$ _____ )
3. Deduct amount for donated and surplus food commodities included in dietary expense (from schedule 16, line 1) . . . . .	(\$ _____ )
4. Deduct revenue (related expense) for food products sold (from schedule 16, line 2) . . . . .	(\$ _____ )
5. NET DIETARY EXPENSES TO ALLOCATE (to line 8 A below) . . . . .	\$ _____

	<u>A. Total</u>	<u>B. Residents' Meals</u>	<u>C. Employees' Meals</u>	<u>D. Meals on Wheels</u>	<u>E. Other</u>	<u>F. Other</u>
6. Meals served . . . . .	_____	_____	_____	_____	_____	_____
7. Ratio to total meals served to 4 decimals	1.0000	_____	_____	_____	_____	_____
8. DIETARY EXPENSE ALLOCATION . . . . . (see instructions below line to complete)	\$ _____ From line 5	\$ _____ 8A X 7B	\$ _____ 8A X 7C	\$ _____ 8A X 7D	\$ _____ 8A X 7E	\$ _____ 8A X 7F
9. Food products provided to employees without charge (from line 2) . . . . .			\$ _____			
10. Deduct revenue from meals sold to employees (from schedule 16, line 3) . . . . .			( _____ )			
11. NET EXPENSE (PROFIT) FOR MEALS AND FOOD PROVIDED TO EMPLOYEES (line 8C + line 9C – line 10C) . . . . .			\$ _____			

**SECTION B – ALLOCATION OF PLANT OPERATION AND MAINTENANCE EXPENSES**

**Non-Nursing Home Areas w/ Plant Operation and Maint.**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>C. Emp. Unique Fringe Benefit Area</u>	<u>D.</u>	<u>E.</u>	<u>F.</u>
12. Total square feet for areas . . . . .	_____	_____	_____	_____	_____	_____
13. Ratio to total square feet to 4 decimals . . . . .	1.0000	_____	_____	_____	_____	_____
14. TOTAL PLANT OP/MAINT EXP. ALLOC.	\$ _____ From S25, L19	\$ _____ 14A X 13B	\$ _____ 14A X 13C	\$ _____ 14A X 13D	\$ _____ 14A X 13E	\$ _____ 14A X 13F

**SCHEDULE 25B – ALLOCATION OF HOUSEKEEPING, LAUNDRY, SECURITY AND TRANSPORTATION**

**SECTION A – ALLOCATION OF HOUSEKEEPING EXPENSES**

**Non-Nursing Home Areas Receiving Housekeeping Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>C.</u>	<u>D.</u>	<u>E.</u>
15. Square feet or hours of service provided	_____	_____	_____	_____	_____
16. Ratio to total sq. ft./ hours to 4 decimals	1.0000	_____	_____	_____	_____
17. TOTAL HOUSEKEEPING EXP. ALLOC.	\$ _____ From S25, L19	\$ _____ 17A X 16B	\$ _____ 17A X 16C	\$ _____ 17A X 16D	\$ _____ 17A X 16E

**SECTION B – ALLOCATION OF LAUNDRY AND LINEN EXPENSES**

**Non-Nursing Home Areas Receiving Laundry/Linen Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>C.</u>	<u>D.</u>	<u>E.</u>
18. Pounds of laundry processed . . . . .	_____	_____	_____	_____	_____
19. Ratio to total pounds to 4 decimals . . . . .	1.0000	_____	_____	_____	_____
20. TOTAL LAUNDRY/LINEN EXP. ALLOC.	\$ _____ From S25, L19	\$ _____ 20A X 19B	\$ _____ 20A X 19C	\$ _____ 20A X 19D	\$ _____ 20A X 19E

**SECTION C – ALLOCATION OF SECURITY EXPENSES**

**Non-Nursing Home Areas Receiving Security Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>C.</u>	<u>D.</u>	<u>E.</u>
21. Total square feet of area . . . . .	_____	_____	_____	_____	_____
22. Ratio to total square feet to 4 decimals . . . . .	1.0000	_____	_____	_____	_____
23. TOTAL SECURITY EXPENSE ALLOC.	\$ _____ From S25, L19	\$ _____ 23A X 22B	\$ _____ 23A X 22C	\$ _____ 23A X 22D	\$ _____ 23A X 22E

**SECTION D – ALLOCATION OF TRANSPORTATION EXPENSES**

**Non-Nursing Home Areas Receiving Transportation Services**

	<u>A. Total</u>	<u>B. Nursing Home Area</u>	<u>C.</u>	<u>D.</u>	<u>E.</u>
24. Alloc. basis, Specify: _____	_____	_____	_____	_____	_____
25. Ratio to total alloc. basis to 4 decimals	1.0000	_____	_____	_____	_____
26. TOTAL TRANS. EXPENSE ALLOC.	\$ _____ From S25, L19	\$ _____ 26A X 25B	\$ _____ 26A X 25C	\$ _____ 26A X 25D	\$ _____ 26A X 25E

**SCHEDULE 26 – ADMINISTRATIVE SERVICE EXPENSES**

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

<b>SECTION A – SALARIES AND WAGES</b>	<b><u>A. General Admin. Serv.</u></b>	<b><u>B. Medical Records</u></b>	<b><u>C. Central Supply</u></b>	<b><u>D. Accounting/Other Serv.</u></b>	<b><u>E. TOTAL (sum A-D)</u></b>
1. TOTAL SALARY AND WAGE EXPENSE.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. NUMBER OF HOURS WORKED. . . . .	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.

Lines 3-5 are no longer used

**SECTION B – RELATED ORGANIZATION CENTRAL SERVICE COSTS**

6. Home office costs allocated to facility (from schedule 26A) . . . . .	\$ _____
7. County costs allocated to facility (from schedule 26A) . . . . .	_____

**SECTION C – NON-SALARY EXPENSES**

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

**SECTION D – TOTAL**

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

**SCHEDULE 26 ATTACHMENT – OTHER NON-SALARY ADMINISTRATIVE SERVICE EXPENSES**

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

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

**SCHEDULE 26A – HOME OFFICE AND COUNTY CENTRAL SERVICE EXPENSES**

**INSTRUCTIONS:** This schedule should be completed by any facility which is related by common ownership or control to a parent organization which provides centralized services to the nursing home or any county-operated nursing home which receives administrative services from centralized county services. Expenses which are indirectly allocated to this facility for home office or county centralized administrative services should be reported on schedule 26. The allocated costs must be reported from the organization's fiscal year which ended during the nursing home's cost report period.

**SECTION A – GENERAL INFORMATION**

1. Name and address of home office or county courthouse \_\_\_\_\_
2. Name and telephone number of contact at home office \_\_\_\_\_

**SECTION B – HOME OFFICE COST ALLOCATION REPORT**

Parent or chain organizations must submit a Home Office Cost Allocation Report or a Medicare Home Office Cost Statement (or other home office report form acceptable to Medicare). A copy of the completed report should be sent to DHS at the Bureau of Nursing Home Services, DLTC, P.O. Box 7851, Madison, WI 53707-7851.

A county facility can base the county centralized service costs allocated to the facility on the countywide cost allocation plan prepared in accordance with the policies and procedures contained in OMB Circular A-87. A separate Home Office Cost Allocation Report does not need to be completed.

**SECTION C – AFFILIATED NURSING HOMES**

Wisconsin Nursing Homes Operated by the Parent Organization or County (add additional sheets if necessary)	City
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

**SECTION D – COSTS ALLOCATED TO THIS FACILITY**

1. Amount of home office or county centralized costs allocated to this facility . . . . . \$ \_\_\_\_\_
2. Deduct the amount of return on owner's equity included in the line 1 amount . . . . . ( \_\_\_\_\_ )
3. Deduct expenses included in line 1 which are directly ascribable to this facility. Reclassify these expenses to their appropriate cost center and specify: \_\_\_\_\_ ( \_\_\_\_\_ )  
 \_\_\_\_\_ ( \_\_\_\_\_ )  
 \_\_\_\_\_ ( \_\_\_\_\_ )
4. NET HOME OFFICE OR COUNTY COSTS ALLOCATED TO THIS FACILITY (to schedule 26, line 6 or 7) . . . . . \$ \_\_\_\_\_
5. Amount on line 4 is from (date) \_\_\_\_\_ through (date) \_\_\_\_\_
6. Amount on line 4 is from (check one)  Home Office Cost Allocation Report  Medicare Home Office Cost Statement  Countywide Cost Allocation Plan

**SCHEDULE 26B – ALLOCATION OF ADMINISTRATIVE SERVICE EXPENSES**

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

1. Total Admin. Service Expense (S26, L12) \$ \_\_\_\_\_

**SECTION A – DIRECT EXPENSES**

**Non-Nursing Home Activities Receiving Administrative Services**

Exp. Directly Ascribable To Each Activity	A. Total	B. NH Provider	C.	D.	E.
2. _____	\$ ( )	\$	\$	\$	\$
3. _____	( )				
4. _____	( )				
5. _____	( )				
6. _____	( )				
7. _____	( )				
8. _____	( )				
9. _____	( )				
10. _____	( )				
11. _____	( )				
12. _____	( )				
13. _____	( )				
14. _____	( )				
15. TOTAL DIRECT EXP. (sum 2-14) . . . . .	\$ ( )	\$	\$	\$	\$
16. NET UNASSIGNED EXP. (line 1-line 15)	\$				

**SECTION B – ALLOC. OF INDIRECT EXP.**

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

**SCHEDULE 27 – OTHER COST CENTERS**

<b>SECTION A – SALARIES AND WAGES</b>	<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>	<b>C.</b>	<b>D.</b>	<b>E.</b>
1. TOTAL SALARY AND WAGE EXPENSE.	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
2. NUMBER OF HOURS WORKED. . . . .	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.	_____ hrs.

<b>SECTION B – NON-SALARY EXPENSES</b>	<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>	<b>C.</b>	<b>D.</b>	<b>E.</b>
3. _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
4. _____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____

<b>SECTION C - TOTAL</b>	<b>A. Nurse Aide Training</b>	<b>B. Beauty/Barber Shop</b>	<b>C.</b>	<b>D.</b>	<b>E.</b>
15. TOTAL EXPENSES (sum 1,3-14) . . . . .	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

**SCHEDULE 28 – EMPLOYEE FRINGE BENEFIT EXPENSES**

**SECTION A – FRINGE BENEFITS PAID ON BEHALF OF EMPLOYEES**

**INSTRUCTIONS:** Under the column labeled "Self-Funded", indicate yes or no. **If yes, attach documentation to support the amount claimed for each self-funded benefit.**

Fringe Benefits Paid on Behalf of Employees			Fringe Benefits Paid on Behalf of Employees		
	Self-Funded?	Expense		Self-Funded?	Expense
1. Employer's share of F.I.C.A. ....	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	10. Uniforms .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
2. State unemployment compensation .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	11. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Federal unemployment compensation .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	12. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Worker's compensation insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	13. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Health insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	14. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Life and disability insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	15. TOTAL PAID ON BEHALF OF EMPLOYEES (sum 1-14) . . . .		_____
7. Wage continuation insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	16. Expense for special salary or wage payments to employees not included elsewhere (see section D) .....		_____
8. Pension and deferred comp. plans (section C)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	17. TOTAL FRINGE BENEFIT EXPENSE (sum 15+16) .....		\$ _____
9. Employee physicals .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____			

**SECTION B – SELF-EMPLOYMENT TAXES**

**INSTRUCTIONS:** If a nursing home is a sole proprietorship or partnership, complete the following for self-employment taxes as reported for the year ending during the cost reporting period. Do not include self-employment taxes in line 1.

Owner's Name	Salary or Net Income	Self-Emp. Tax Paid	Owner's Name	Salary or Net Income	Self-Emp. Tax Paid
_____	\$ _____	\$ _____	_____	\$ _____	\$ _____
_____	\$ _____	\$ _____	_____	\$ _____	\$ _____

**SECTION C – PENSION AND DEFERRED COMPENSATION PLANS**

**INSTRUCTIONS:** For the purpose of benefits, some pension plans recognize years of service built up by employees before the plan was established. Briefly explain how the pension expense for service from prior years is amortized to or recognized in this cost reporting period. List the amount of expense for prior year service included in line 8.

**SECTION D – SPECIAL SALARY AND WAGE PAYMENTS TO EMPLOYEES**

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

- Christmas bonus       Longevity bonus       Productivity bonus       Other, Specify: \_\_\_\_\_
- Bonuses to owners and immediate family relations, Specify: \_\_\_\_\_

**SCHEDULE 29 – HEATING FUEL AND UTILITY EXPENSES**

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

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

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

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

<u>SECTION A – ACCRUED EXPENSE BY TYPE</u>	<u>Accrued Expense</u>	<u>Expense by Type</u>	<u>Accrued Expense</u>
1. Fuel oil . . . . .	\$ _____	6. Water and sewer utility charges . . . . .	\$ _____
2. Natural gas . . . . .	_____	7. Purchased steam . . . . .	_____
3. L.P. gas . . . . .	_____	8. _____	_____
4. Coal . . . . .	_____	9. _____	_____
5. Electricity . . . . .	_____	10. TOTAL FUEL AND UTILITY EXPENSE . . .	\$ _____

**SECTION B – ALLOCATION OF FUEL AND UTILITY EXPENSE**

**Non-NH Areas, Other Rev. Areas Receiving Fuel/Util. Serv.**

	<u>A. Total</u>	<u>B. NH Area</u>	<u>C. Emp. Unique Fringe Ben. Area</u>	<u>D.</u>	<u>E.</u>	<u>F.</u>
11. Total square feet for areas . . . . .	_____	_____	_____	_____	_____	_____
12. Ratio to total square feet to 4 decimals .	1.0000	_____	_____	_____	_____	_____
13. TOTAL ALLOC. FUEL/UTIL. EXPENSE	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____
	From line 10	13A X 12B	13A X 12C	13A X 12D	13A X 12E	13A X 12F

### SCHEDULE 30 – INTEREST EXPENSES ON OPERATING WORKING CAPITAL LOANS

Name of Lender	Is Lender a Related Party?	Interest Expense
1a. _____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
2a. _____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3a. _____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4a. _____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5a. _____	b. <input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. TOTAL EXPENSES ON OPERATING WORKING CAPITAL LOANS (sum 1-5) .....		\$ _____

### SCHEDULE 31 – INSURANCE EXPENSES

Type of Insurance Coverage	Self-funded?	Insurance Expense
1. Property insurance on building and contents .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____
2. Automobile insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Liability insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Business interruption insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Life insurance on owners and employees with facility as the beneficiary .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Mortgage insurance .....	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. TOTAL INSURANCE EXPENSE .....		\$ _____

### SCHEDULE 32 – AMORTIZATION OF DEFERRED EXPENSES

A. Deferred Expense or Asset Being Amortized (give detailed description)	B. Original Cost	C. Year Cost Incurred	D. Number of Years Amortized	E. Unamortized Beginning Balance	F. Unamortized Ending Balance	G. Amortization Expense
1. _____	\$ _____	_____	_____	\$ _____	\$ _____	\$ _____
2. _____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____
5. TOTAL AMORTIZATION EXPENSE .....						\$ _____

**SCHEDULE 33 – INTEREST EXPENSES ON PLANT ASSET LOANS**

Lender Name and Purpose of Loan	A. Original Month, Year of Loan	B. Maturing Month, Year of Loan	C. Original Amount of Loan	Remaining Balance of Loan Principal			G. Interest Rate	H. Interest Expense
				D. Begin date	E. 6Mo.date	F. End date		
				Begin Bal.	6 Mo. Bal.	End Bal.		
1a.Name _____ 1b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 1c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
2a.Name _____ 2b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 2c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
3a.Name _____ 3b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 3c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
4a.Name _____ 4b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 4c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
5a.Name _____ 5b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 5c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
6a.Name _____ 6b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 6c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
7a.Name _____ 7b. Related party? <input type="checkbox"/> Yes <input type="checkbox"/> No 7c.Purpose _____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____%	\$ _____
8. TOTAL LOAN PRINCIPAL .....				\$ _____	\$ _____	\$ _____	TOTAL EXP.	\$ _____

### SCHEDULE 34 – DEPRECIATION EXPENSES

**SECTION A – CAPITALIZED HISTORICAL COST**

	Begin Date _____ B. Beginning Balance	C. Additions During Report Period	D. Disposals During Report Period	End Date _____ E. Ending Balance
1. Land . . . . .	\$ _____	\$ _____	\$ ( _____ )	\$ _____
2. Land improvements . . . . .	_____	_____	( _____ )	_____
3. Buildings . . . . .	_____	_____	( _____ )	_____
4. Leasehold improvements . . . . .	_____	_____	( _____ )	_____
5. Fixed equipment . . . . .	_____	_____	( _____ )	_____
6. Moveable equipment . . . . .	_____	_____	( _____ )	_____
7. Transportation vehicles . . . . .	_____	_____	( _____ )	_____
8. _____	_____	_____	_____	_____
9. _____	_____	_____	( _____ )	_____
10. TOTAL CAPITALIZED COST . . .	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ ( _____ )</u>	<u>\$ _____</u>

**SECTION B – DEPRECIATION EXPENSE AND ACCUMULATION DEPRECIATION**

	A. Depreciation Method, Lives Used	Begin Date _____ B. Beginning Balance	C. Depreciation Exp. During Report Period	D. Removal of Accum. Deprec. on Disposals.	End Date _____ E. Ending Balance
11. Land improvements . . . . .	_____	\$ _____	\$ _____	\$ ( _____ )	\$ _____
12. Buildings . . . . .	_____	_____	_____	( _____ )	_____
13. Leasehold improvements . . . . .	_____	_____	_____	( _____ )	_____
14. Fixed equipment . . . . .	_____	_____	_____	( _____ )	_____
15. Moveable equipment . . . . .	_____	_____	_____	( _____ )	_____
16. Transportation vehicles . . . . .	_____	_____	_____	( _____ )	_____
17. _____	_____	_____	_____	_____	_____
18. _____	_____	_____	_____	( _____ )	_____
19. TOTAL ACCUMULATED DEPRECIATION . . . . .		<u>\$ _____</u>		<u>\$ ( _____ )</u>	<u>\$ _____</u>
20. TOTAL DEPRECIATION EXPENSE . . . . .			<u>\$ _____</u>		

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

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

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

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

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

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

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

**SECTION A – LEASE EXPENSE FOR LAND, BUILDING AND FIXED EQUIPMENT**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (if known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	\$ _____
2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____
3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____

**SECTION B – LEASE EXPENSE FOR MOVEABLE EQUIPMENT AND OTHER LEASES**

A. Name of Lessor	B. Related Party?	C. Lease Purchase Agreement?	D. Lessor Acquisition Cost (if known)	E. Month, Year acquired use	F. Describe Property	G. Lease Exp.
4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	\$ _____
5. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____
6. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____
7. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____
8. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$ _____	_____	_____	_____

**SECTION C – TOTAL**

9. TOTAL LEASE EXPENSE ON OPERATING LEASES AND NON-CAPITALIZED LEASES (sum 1-8) ..... \$ \_\_\_\_\_

## SCHEDULE 36 – LEASE EXPENSES ON CAPITALIZED LEASES

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

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

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

**SECTION A – CAPITALIZED LEASE INFORMATION**

	<u>Lease Expense</u>
1. Name of lessor . . . . . _____	1a. Amortization of capitalized lease value . . . . . \$ _____
Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	1b. Interest expense on capital lease obligation . . . . . _____
Date use of property was acquired . . . . . _____	1c. Accrued contingent lease payments for period . . . . . _____
Ensuring date of lease . . . . . _____	1d. SUBTOTAL LEASE EXPENSE (sum 1a-1c) . . . . . \$ _____
Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Description of leased property . . . . . _____	
2. Name of lessor . . . . . _____	2a. Amortization of capitalized lease value . . . . . \$ _____
Is lessor a related party? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	2b. Interest expense on capital lease obligation . . . . . \$ _____
Date use of property was acquired . . . . . _____	2c. Accrued contingent lease payments for period . . . . . \$ _____
Ensuring date of lease . . . . . _____	2d. SUBTOTAL LEASE EXPENSE (sum 2a-2c) . . . . . \$ _____
Is this a lease purchase agreement? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Description of leased property . . . . . _____	
3. TOTAL CAPITALIZED LEASE EXPENSE FOR REPORTING PERIOD – transfer to schedule 12 (sum 1d+2d) . . . . .	\$ _____

**SECTION B – ACTUAL LEASE PAYMENTS RELATED TO CAPITALIZED LEASES**

A1. Name of lessor . . . . . _____	A2. Actual payments required by lease in report period . . . \$ _____
A3. Are any capitalized costs reported on other schedules? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	A4. If yes, (schedule) _____ (line) _____ (amount) \$ _____
B1. Name of lessor . . . . . _____	B2. Actual payments required by lease in report period . . . \$ _____
B3. Are any capitalized costs reported on other schedules? . . . . . <input type="checkbox"/> Yes <input type="checkbox"/> No	B4. If yes, (schedule) _____ (line) _____ (amount) \$ _____

### SCHEDULE 37 – PROPERTY TAX EXPENSES

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

**SECTION A – REAL ESTATE, PERSONAL PROPERTY, AND MUNICIPAL SERVICE EXPENSES**

	Expense
1. Real estate tax .....	\$ _____
2. Personal property tax .....	_____
3. _____ \$ _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. TOTAL MUNICIPAL SERVICE EXPENSES (sum 3-6) .....	\$ _____
8. TOTAL PROPERTY TAX AND/OR MUNICIPAL SERVICE EXPENSE (sum 1,2,7) .....	\$ _____

**SECTION B – FOR ALL PROVIDERS**

	Expense
1. 2009 real estate tax (due in 2010) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)	\$ _____
2. 2009 personal property tax (due in 2010) relating to the nursing home operation (attach copy bill or, if not yet received, send separately upon receipt.)	_____
3a. Have the amounts reported on lines 1 and 2 been paid in full? <input type="checkbox"/> Yes, go to question 3b <input type="checkbox"/> No, explain below Date(s) paid _____ Amount(s) paid _____ Amount still outstanding _____	_____
3b. Are there any real estate or personal property tax still outstanding from prior years, eg. 2007 or 2008? <input type="checkbox"/> Yes, explain below <input type="checkbox"/> No Tax year _____ Amount still outstanding _____ Tax year _____ Amount still outstanding _____	_____

**SECTION C – FOR TAX-EXEMPT PROVIDERS ONLY**

	Expense
4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2009.	\$ _____
5. Identify where municipal service fee expenses are reported in the cost report if not above on this schedule, section A, line 7. Cost center name _____ Schedule number _____ Line number _____ Amount reported _____	\$ _____
6. The facility began to pay municipal service fees (check one) <input type="checkbox"/> Prior to January 2009 <input type="checkbox"/> In or after January 2009 Date began paying fees _____	_____
7. Describe the services provided by the municipality for the above fees. _____ _____	_____
8. Payment of the above fees was (check one) <input type="checkbox"/> Voluntary <input type="checkbox"/> Required by the tax authority	_____

**SCHEDULE 38 – INCOME TAX EXPENSES**

**INSTRUCTIONS:** Completion of this schedule is optional. Report estimated income tax.

Type of Tax	Tax Expense
1. State income tax . . . . .	\$ _____
2. Federal income tax . . . . .	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. TOTAL ESTIMATED INCOME TAX EXPENSES (sum 1-5) . . . . .	\$ _____

**SCHEDULE 39 – OTHER NON-SALARY EXPENSES**

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

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

### SCHEDULE 40 – ALLOCATION OF PROPERTY EXPENSES

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

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

## SCHEDULE 41 – ACCOUNTING AND REPORTING POLICIES

### SECTION A – POLICIES AND PRACTICES

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

2. Capitalization of plan assets – briefly describe the facility’s policy or practice for the capitalization of plant asset purchases.

\_\_\_\_\_

\_\_\_\_\_

3. Volunteer and unpaid employees – briefly explain if and how volunteer and other unpaid employee hours are reported in this cost report

\_\_\_\_\_

\_\_\_\_\_

4. Conformity – describe any accounting practices/policies in reporting revenues and expenses which are known to NOT conform to generally accepted accounting principles.

\_\_\_\_\_

\_\_\_\_\_

### SECTION B – NON-PRODUCTIVE SALARY EXPENSE AND HOURS

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

Type of Paid Time-Off	A. Based on Actual or Earned Time-Off?		B. Are Reported Amounts an Estimate?	
1. Vacation . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Holidays . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Sick time . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Break, meal time . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Holiday premium . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. In-service training . . . . .	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. _____	<input type="checkbox"/> Actual	<input type="checkbox"/> Earned	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**SCHEDULE 42 – IDENTIFICATION OF EXPENSES FROM TRANSACTIONS WITH RELATED PARTIES AND ORGANIZATIONS**

**SECTION A – RELATED PARTY LEASES**

A. Description of Expense Item	Location and Amount of Expense Included In This Cost Report					G. Expense Incurred by Related Party	H. Difference (G – F)
	B. Cost Ctr.	C. Schedule	D. Column	E. Line	F. Expense		
1. Total related party lease expense . . . . .					\$ ( )	XXXXXXXXXX	XXXXXXXXXX
2. Insurance expense . . . . .					XXXXXXXXXX		XXXXXXXXXX
3. Amortized deferred expense . . . . .					XXXXXXXXXX		XXXXXXXXXX
4. Interest expense . . . . .					XXXXXXXXXX		XXXXXXXXXX
5. Depreciation expense . . . . .					XXXXXXXXXX		XXXXXXXXXX
6. Property tax expense . . . . .					XXXXXXXXXX		XXXXXXXXXX
7. _____					XXXXXXXXXX		XXXXXXXXXX
8. _____					XXXXXXXXXX		XXXXXXXXXX
9. SUBTOTAL FOR RELATED PARTY LEASES . . . . .					\$ ( )	\$	\$

**SECTION B – OTHER RELATED PARTY TRANSACTIONS**

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

**SECTION C – IDENTIFICATION OF RELATED PARTIES**

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SCHEDULE 43 – IDENTIFICATION OF EXPENSES NOT RELATED TO PATIENT CARE**

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

Expense Item	Amount	Location of Expense In Cost Report			
		Cost Ctr.	Schedule	Column	Line
1. Promotional expenses . . . . .	\$				
2. Gifts and flowers . . . . .					
3. Personal expenses of owners . . . . .					
4. Entertainment for non-residents . . . . .					
5. Telephone, television, and radio in resident rooms . . . . .					
6. Contributions and donations . . . . .					
7. Fines and penalties . . . . .					
8. Interest expense on non-care working capital loans . . . . .					
9. Interest expense on non-care plant asset loans . . . . .					
10. Non-care related membership fees . . . . .					
11. Training programs for non-employees . . . . .					
12. Special legal and professional fees (complete schedule 43A) . . . . .					
13. Owner or key person life insurance . . . . .					
14. Taxes . . . . .					
15. Fund raising expenses . . . . .					
16. Excess property . . . . .					
17. _____					
18. _____					
19. _____					

**SCHEDULE 43A – LEGAL FEES**

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

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

**SCHEDULE 44 – IDENTIFICATION OF COMPENSATION TO KEY PERSONNEL**

**INSTRUCTIONS:** Report the compensation paid to all owners and other related parties and immediate family relationships, all workers who are members of a religious order or society that owns the nursing home, and arm's length employees who are supervisors or managers with decision making authority. See reference charts below for columns B & D.

A. Name	B. Title (see list below)	C. Sex	D. Level of Education	E. Years of Experience	F. Total Comp. Expense This Facility	G. Hours per Year This Facility	H. Hrs. per Yr. Other Health Care Provider	I. Member of Religious Order?	J. Owner or Family Relation?
1. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	\$ _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. _____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Fem.	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. TOTAL COMPENSATION FOR THIS FACILITY .....					\$ _____				

TITLE / RESPONSIBILITY AREA (Column B)				LEVEL OF EDUCATION (Column D)	
ADM	Administrator	DON	Director of Nursing	HS	High School Diploma
ASST ADM	Assistant Administrator	NURSE	Nursing Supervisor	NS	Nursing School Diploma, Associate Degree
OTH ADM	Other Administrator, Specify.	DIET	Dietary Supervisor	BS	Baccalaureate Degree (BS, BA, BSN)
CFO	Chief Financial Officer	MAINT	Maintenance Supervisor	MS	Master's Degree (MS, MA, MSN)
BUS MGR	Business Manager	HSK	Housekeeping Supervisor	PHD	Doctorate Degree
PERSON	Personnel Manager	LAUND	Laundry Supervisor		
		OTHER	Other, Specify.		

**SCHEDULE 45 – DISTRIBUTION OF COMPENSATION EXPENSES TO KEY PERSONNEL**

**INSTRUCTIONS:** For each person listed on schedule 44, separately itemize and identify the amount of compensation expense and hours reported in each cost center of this cost report. Total compensation reported on this schedule should agree with the total reported on schedule 44, column F.

A. Name	Location of Expense in Cost Report			Compensation & Hours		Purchased Services	
	B. Cost Ctr.	C. Schedule	D. Column	E. Expense	F. Hours	G. Expense	H. Hours
1. _____	_____	_____	_____	\$ _____	Hrs. _____	\$ _____	Hrs. _____
2. _____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____	_____
13. TOTAL EXPENSE (for columns E and G only) .....				\$ _____		\$ _____	

### SCHEDULE 46 – IDENTIFICATION OF EXPENSES FOR EMPLOYEE UNIQUE FRINGE BENEFITS

**INSTRUCTIONS:** Unique fringe benefits are those fringe benefit items provided to only a few select employees and the expenses for such benefits may be reported in one or more cost centers of this report. Identify the unique fringe benefits provided to any individual employee by reporting the expenses related to the benefit and where the expenses are included in this cost report. If the expense for a benefit is less than \$800 per year, it does not have to be reported on this schedule.

A. Name of Employee	B. Title	C. Describe Unique Fringe Benefit Item	D. Cost Ctr. Salary Exp.	<u>Location and Amount of Benefit Expense in Cost Report</u>				I. Benefit Expense Amount
				E. Cost Ctr. Benefit Exp.	F. Schedule	G. Column	H. Line	
1. _____	_____	_____	_____	_____	_____	_____	_____	\$ _____
2. _____	_____	_____	_____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____	_____	_____	_____	_____
7. _____	_____	_____	_____	_____	_____	_____	_____	_____
8. _____	_____	_____	_____	_____	_____	_____	_____	_____
9. _____	_____	_____	_____	_____	_____	_____	_____	_____
10. _____	_____	_____	_____	_____	_____	_____	_____	_____
11. _____	_____	_____	_____	_____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____	_____	_____	_____	_____
15. _____	_____	_____	_____	_____	_____	_____	_____	_____
16. _____	_____	_____	_____	_____	_____	_____	_____	_____

**SCHEDULE 47 – ADMINISTRATIVE SERVICES PROVIDED TO OTHER NURSING HOMES AND ENTERPRISES**

**INSTRUCTIONS:** On this schedule, report only the key administrative personnel identified on schedule 44 who also have responsibility for certain areas other than this nursing home. For supervisors or managers with decision making authority for another nursing home, a hospital, a community-based residential facility (CBRF), or an apartment complex, identify the employee(s) and the total number of beds/units in the appropriate column.

Name	Number of Beds in Each Facility			
	Other Nursing Homes	Hospitals	CBRFs	Apartments
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____
5. _____	_____	_____	_____	_____
6. _____	_____	_____	_____	_____

**SCHEDULE 48 – OUT-OF-STATE TRAVEL EXPENSES**

**INSTRUCTIONS:** Report the amount of out-of-state travel expenses included in this cost report but do NOT include expenses for travel to and from the facility's home office, travel within 100 miles of the Wisconsin border, or travel for home office personnel when one or more associated nursing homes are located outside of Wisconsin. Types of travel expenses that should be included are meals, lodging, transportation, and training, seminar, and convention fees/expenses associated with out-of-state trips. Attach additional sheets if necessary.

Employee Name, Destination, Purpose of Trip	Schedule	Line	Amount
1. _____	_____	_____	\$ _____
2. _____	_____	_____	\$ _____
3. _____	_____	_____	\$ _____

**SCHEDULE 49 – PERCENTAGE OF OWNERSHIP**

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

	Name of Individual or Entity	Percentage of Ownership
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

**SCHEDULE 50 – INTEREST IN OTHER MEDICAID PROVIDERS**

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

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

**SCHEDULE 51 – MEDICAL SUPPLY REVENUES FROM MEDICARE PART B**

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

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

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

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

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

5. What were the Medicare Part B revenues for medical supplies? ..... \$ \_\_\_\_\_

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

a. Expense \$ \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_

b. Expense \$ \_\_\_\_\_ schedule \_\_\_\_\_ column \_\_\_\_\_ line \_\_\_\_\_

**SCHEDULE 52 – MISCELLANEOUS MEDICAID NON-RATE REVENUES**

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

On lines 1 and 2, the amounts reported should only reflect the revenues in excess of the Medicaid daily rate for residents' levels of care and for which the related expenses are included in this cost report. For example, a resident at the ISN level of care is also authorized for a supplemental payment of \$325 per day as an extensive care patient. The facility's ISN rate is \$102 per day. The revenue reported on this schedule in excess of the of the level of care daily rate is \$223 per day.

On line 5, report the amount of reimbursement from the Medicaid program for specialized services (active treatment) for mentally ill residents who were determined to be in need of such services by a level II pre-admission screening and annual resident review.

Medicaid Revenue Item	Revenue Amount	Location in Cost Report	
		Schedule	Line
1. Extensive care patients excluding ventilator- dependent . . . . .	\$ _____	_____	_____
2. Residents with AIDS or AIDS-related complex . . . . .	_____	_____	_____
3. Exceptional supply needs . . . . .	_____	_____	_____
4. Personalized durable medical equipment including Clinitron beds and motorized wheelchairs . . . . .	_____	_____	_____
5. Specialized services for the mentally ill . . . . .	_____	_____	_____
6. Level 1 screening (number of screenings) _____ X (payment per screening) \$ _____ = _____	_____	_____	_____
7a. Nurse aide training and competency evaluations – revenues from training aides for other facilities . . . . .	_____	_____	_____
7b. Nurse aide training and competency evaluations – revenues from training aides for your own facility . . . . .	_____	_____	_____
7c. Nurse aide training and competency evaluations – revenues for performing competency evaluations . . . . .	_____	_____	_____
8. TOTAL MISCELLANEOUS MEDICAID NON-RATE REVENUES (sum 1-7) . . . . .	\$ _____	_____	_____

### SCHEDULE 53 – INCENTIVES – PRIVATE ROOM & PROPERTY

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

**Indicate if your facility is requesting a private room incentive**

- YES, my facility is requesting a private room incentive. If YES specify one:     BPRI     RPPRI  
 NO, my facility is not requesting the BPRI or RPPRI.

If your facility is requesting one of the incentives, you must complete the affidavit below and return it to the Department by July 1, 2010, to qualify for one of the private room incentives.

#### AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2010, to June 30, 2011, the \_\_\_\_\_ nursing home will not charge/has not charged Medicaid residents any amount for private rooms including but not limited to the surcharge as provided under Ch DHS 107.09(4)(k), Wis. Admin. Rules. I furthermore acknowledge that all payments the facility has received for the Medicaid Basic Private Room Incentive (BPRI) or Replacement Private Room Incentive (RPPRI) may be recouped retroactive to July 1, 2010, if the facility has charged Medicaid residents for private rooms during this period.

<b>SIGNATURE</b> – Original Signature of Officer or Administrator of Nursing Home	Title	Date
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**PROPERTY INCENTIVE:**

Did the facility get approval for \$135,000 URC on New Total Replacement Constriction? See Sec. 4.920 of Methods of Implementation     YES     NO

Did the facility get approval for \$10 per patient day for “Innovative Area”? See Sec. 3.655 of Methods of Implementation     YES     NO

**If YES to either question above – Complete the Following -**

Date Approval Received: \_\_\_\_\_

Has Construction Begun?     YES     NO    If YES, when did it begin? \_\_\_\_\_

Has construction been completed?     YES     NO    If completed, when was it completed? \_\_\_\_\_

Number of beds in Replacement Facility or “Innovative Area” \_\_\_\_\_

During this cost report period -

Number of Medicaid Fee For Service Patient days in Replacement Facility or “Innovative Area”? \_\_\_\_\_

Number of Medicaid Family Care Patient days in Replacement Facility or “Innovative Area”? \_\_\_\_\_

Number of Medicaid Partnership Patient days in Replacement Facility or “Innovative Area”? \_\_\_\_\_

<b>For Department Use</b>	Date Received	Medicaid District Auditor
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