

WISCONSIN MEDICAID PROGRAM 2011 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 Email 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**

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.

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;"> <thead> <tr> <th style="width: 50%;"></th> <th style="width: 10%; text-align: center;">DATE</th> <th style="width: 10%; text-align: center;">BEDS</th> <th style="width: 30%;"></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;"><u>Beds at Beginning of Cost Reporting Period</u></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td rowspan="4" style="text-align: center; vertical-align: middle;">For Department Use – Average Beds</td> </tr> <tr> <td style="text-align: center;"><u>Beds at End of Cost Reporting Period</u></td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">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="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> <tr> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table>		DATE	BEDS		<u>Beds at Beginning of Cost Reporting Period</u>	_____	_____	For Department Use – Average Beds	<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.	_____	_____	_____	_____	_____			
	DATE	BEDS																		
<u>Beds at Beginning of Cost Reporting Period</u>	_____	_____	For Department Use – Average Beds																	
<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

1. MONTH	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	TOTAL
2. Days in Month. . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
3. Licensed Beds for Bedhold Testing. . . .	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
4. Occupancy Test -: Row 2 X (Row 3 X 94%)	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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
CURRENT ASSETS	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:	_____	_____	
_____	_____	_____	
_____	_____	_____	
TOTAL CURRENT ASSETS	\$ _____	\$ _____	
PROPERTY, PLANT, EQUIP.	Land	\$ _____	\$ _____
	Land improvements	_____	_____
	Buildings	_____	_____
	Leasehold improvements	_____	_____
	Fixed equipment	_____	_____
	Moveable equipment	_____	_____
	Transportation equipment	_____	_____
	Other	_____	_____
	Less: accumulated depreciation	(_____)	(_____)
TOTAL PROPERTY, PLANT, EQUIPMENT	\$ _____	\$ _____	
OTHER	Long term investments	\$ _____	\$ _____
	Other Assets, list below:	_____	_____
	_____	_____	_____
TOTAL OTHER ASSETS	\$ _____	\$ _____	
TOTAL ASSETS	\$ _____	\$ _____	

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

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

Cost Center and Schedule		Total Salary and Wage Expense (Line 1 or 5)	Cost Center and Schedule		Total Salary and Wage Expense (Line 1 or 5)
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.

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

SECTION B – BEDHOLD CHARGES	
5. Medicaid	_____
6. Private Pay	_____
7. Other	_____

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

SECTION D – TOTAL	
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 . .	<u>\$ _____</u>	<u>\$ _____</u>	<u>\$ _____</u>	

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

	Revenue	A. Related Direct Expense (if known)	B. Cost Center where expense included	C. Schedule Number	D. Line Number
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.

SECTION C – RENTAL REVENUE	<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>			

SECTION D – REVENUE FROM MAJOR ACTIVITIES	<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

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

SECTION F – INTEREST AND INVESTMENT REVENUE		Revenue	SECTION I – GRANTS, CONTRIBUTIONS, DONATIONS		Revenue
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		<u>\$ _____</u>	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 . .		<u>\$ _____</u>
		_____	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.		_____

SECTION G – GAINS (LOSSES) DISPOSAL OF ASSETS		Gain (Loss)	SECTION J – OTHER REVENUES		Revenue
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		<u>\$ _____</u>
52. Other assets, Specify: _____		_____			
53. TOTAL GAINS (LOSSES) ON DISPOSAL OF ASSETS . . .		<u>\$ _____</u>			

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

NURSING AND INCONTINENCY SUPPLIES

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	\$ _____	\$ _____	\$ _____
SECTION B – PURCHASED SERVICES			
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.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. Pharmacy – legend drugs - Billable	\$ -0-	\$ -0-	\$ _____
11. Pharmacy – over the counter drugs - Billable	-0-	-0-	_____
12. Supply and Other	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
SECTION D – TOTAL			
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	\$ _____	\$ _____	\$ _____
SECTION B – PURCHASED SERVICES			
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.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. _____	\$ _____	\$ _____	\$ _____
11. _____	_____	_____	_____
12. _____	_____	_____	_____
13. _____	_____	_____	_____
14. _____	_____	_____	_____
SECTION D – TOTAL			
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
SECTION A – SALARY AND WAGES			
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	\$	\$	\$
SECTION B – PURCHASED SERVICES			
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.
SECTION C – SUPPLY AND OTHER EXPENSE			
10. _____	\$	\$	\$
11. _____			
12. _____			
13. _____			
14. _____			
SECTION D - TOTAL			
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
SECTION A – SALARY AND WAGES				
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	\$ _____	\$ _____	\$ _____	\$ _____
SECTION B – PURCHASED SERVICE				
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.
SECTION C – SUPPLY AND OTHER EXPENSE				
10. _____	\$ _____	\$ _____	\$ _____	\$ _____
11. _____	_____	_____	_____	_____
12. _____	_____	_____	_____	_____
13. _____	_____	_____	_____	_____
14. _____	_____	_____	_____	_____
SECTION D - TOTAL				
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.
SECTION A – SALARY AND WAGES				
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	\$	\$	\$	\$
SECTION B – PURCHASED SERVICE				
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.
SECTION C – SUPPLY AND OTHER EXPENSE				
10. _____	\$	\$	\$	\$
11. _____				
12. _____				
13. _____				
14. _____				
SECTION D - TOTAL				
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

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

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

SECTION A – ALLOCATION 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.

SECTION A – SALARIES AND WAGES A. General Admin. Serv. B. Medical Records C. Central Supply D. Accounting/Other Serv. E. TOTAL (sum A-D)

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)	<u>\$ _____</u>

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 Financial Management, 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

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

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

SECTION C - TOTAL	A. Nurse Aide Training	B. Beauty/Barber Shop	C.	D.	E.
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.

SECTION A – ACCRUED EXPENSE BY TYPE	Accrued Expense	Expense by Type	Accrued Expense
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.					
	A. Total	B. NH Area	C. Emp. Unique Fringe Ben. Area	D.	E.	F.
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 . . .	\$ _____	\$ _____	\$ (_____)	\$ _____

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		\$ _____		\$ (_____)	\$ _____
20. TOTAL DEPRECIATION EXPENSE			\$ _____		

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

	<u>Expense</u>
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

	<u>Expense</u>
1. 2010 real estate tax (due in 2011) relating to the nursing home operation (attach copy of bill or, if not yet received, send separately upon receipt.)	\$ _____
2. 2010 personal property tax (due in 2011) 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, e.g., 2008 or 2009? <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

	<u>Expense</u>
4. Amount of municipal service fee expense incurred by the nursing home appropriately accrued to calendar year 2010.	\$ _____
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 2010 <input type="checkbox"/> In or after January 2010 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, 2012, to qualify for one of the private room incentives.

AFFIDAVIT

I HEREBY ATTEST and affirm that from July 1, 2012, to June 30, 2013, 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, 2012, if the facility has charged Medicaid residents for private rooms during this period.

SIGNATURE – Original Signature of Officer or Administrator of Nursing Home	Title	Date
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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”? _____

For Department Use	Date Received	Medicaid District Auditor
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