Chapter 4-A Instructions for Filing Long-Term Care Nursing Facility Cost Report

4-1A Instructions

The DOM-400 cost reporting forms described below must be used by all long-term care Nursing Facilities participating in the Arkansas Medicaid Program. Medicare (Title XVIII) cost reporting forms are not acceptable in lieu of these forms.

4-2A General Information

These instructions are for use in the preparation and submission of the cost report to the Division of Medical Services by all Nursing Facilities providing care and services under the Medical Assistance Program. All ICF/MR facilities will continue to use the Financial and Statistical Report, DHS-750 and applicable instructions.

Only per diem cost amounts calculated on Form 6, Line 12 and employee beginning hourly rates identified on Form 16, Column 4 will be reported/calculated in cents. All other dollar amounts must be rounded to the nearest dollar (no cents) upon transfer to the cost report.

Detailed schedules, calculations and descriptions for all cost report adjustments must be attached to the submitted cost report.

Cost report forms that are not applicable to a facility must be submitted with the other forms and identified as "Not Applicable" or "NA" on the unused form.

Facilities which are combined with or attached to other operations (hospitals, RCF's, etc.) sometimes use one common accounting system and general ledger. For such facilities, adjusting entries must be made to the trial balance before the amounts are posted to the Nursing Facility cost report forms. The trial balance submitted with the cost report must reflect the general ledger amounts, any adjustments necessary to remove amounts applicable to other operations, and the net adjusted trial balance amounts applicable to the Nursing Facility. Copies of workpapers used to make these adjustments must be attached to the submitted trial balance. These workpapers will identify adjustment amounts, descriptions, ledger balances affected, and allocation methods used.

4-3A Instructions for Cost Report Forms

A. Form 1 General Information

1. I. Provider Facility

a) Facility Name:
The true name of the long term care facility as licensed by the Department of Human Services, Division of Medical Services.

b) Provider Number:
The facility's Medicaid provider number in effect for the dates of the cost report. This is the nine (9) digit number used to bill for Medicaid services.

c) D/B/A:
The name by which the long term care facility operates (complete only if different from facility name above).

d) State Vendor Number:
The facility's four (4) digit State Vendor Number.

e) Address:
Facility's physical location address.

f) County:
The county in which the facility is located.

g) County Number:
The county's two (2) digit identification number.

h) Administrator and AR License Number:
The facility's administrator at the close of the cost reporting period and their Arkansas license number.

i) Phone:
Facility telephone number.

j) Contact Person:
The person employed by the facility who should be contacted regarding the cost report and their telephone number.

k) Report Period:
Identify the reporting period and the number of months covered by the cost report.

l) Financial Records For Audit Are Located At
Identify where the financial records used to complete the cost report are located.

m) All Correspondence and Desk Reviews Regarding This Cost Report Should Be Addressed To (Limited to one name and address):
List the name, address and telephone number of the person to whom all correspondence, desk reviews, audits, etc. should be addressed. Each facility is allowed only one name and address in this section.

2. II. Home Office

Complete this section only if the facility has a home office.

3. III. Management Company

Complete this section if the facility pays management fees. A narrative description of purchased management services or a copy of contracts for managed services must be submitted with the cost report in order for management fees to be allowed. Check the applicable identification as to whether the management company is related party or non-related.

4. IV. For Division of Medical Services use only

Do not complete this section.

B. Form 2 Certification by Officer or Administrator of Provider

The Certification by Officer or Administrator of Provider is required and must include an original signature (not a copy) by an authorized officer or the administrator of the facility. The cost report will not be deemed received by the Division of Medical Services if this certification has not been completed.

The cost report may be completed by the facility's employees, owners, independent accountants, or other qualified parties. If a Certified Public Accountant prepares the cost report, the cost report must be accompanied by the appropriate compilation, review or audit report. The cost report must be completed in addition to any other items required by the Guidelines for Financial and Compliance Audits of Programs Funded by the Arkansas Department of Human Services.

C. Form 3 Statistical Data

1. Line 1, 2, and 3
Check the appropriate blocks that apply to your facility. Check only one block on each of Lines 1 and 3. Line 2 must have a box checked on each of Lines A, B, C and D. Line 2B and/or 2C should be checked “Yes” if any owner (individual, partnership, corporation, etc.) of this facility with a 5% or greater ownership also owns a 5% or greater share of any other nursing facility/facilities.

2. Line 4.1, Resident Days by Payment Source
Complete the number of actual resident days by type of resident (payment source).

a) Column (A) Total
Column (B) plus Column (C) plus Column (D) plus Column (E).

b) Column (B) Medicaid
All Medicaid reimbursed days will be identified here. This category will also include Medicaid reimbursed reserved bed days due to hospitalization and therapeutic home leave.

c) Column (C) Medicare
All Medicare reimbursed days will be identified here.

d) Column (D) Private Pay
All private pay reimbursed days by the resident, resident's family, etc. will be identified here. This category will also include private pay reimbursed reserved bed days due to hospitalization and home therapeutic leave.

e) Column (E) Other
All third party (VA, other insurance), hospice, respite care, etc. reimbursed days will be identified here. This category will also include other reimbursed reserved bed days due to hospitalization and home therapeutic leave.

3. Line 4.2, Resident Days by Level of Care
Complete the number of actual resident days by resident level of care - Column (A) Total resident days, Column (B) Skilled resident days, Column (C) Intermediate I resident days, Column (D) Intermediate II resident days, and Column (E) Intermediate III resident days. Line 4.2, Column A must agree with Line 4.1, Column A.

4. Line 4.3, Medicaid Resident Days by Level of Care
Complete the number of Medicaid resident days by resident level of care - Column (A) Total Medicaid resident days, Column (B) Skilled resident days, Column (C) Intermediate I resident days, Column (D) Intermediate II resident days, and Column (E) Intermediate III resident days. Line 4.3, Column A must agree with Line 4.1, Column B.

5. Lines 5 and 6
Identify the number of beds licensed at the beginning and end of the period. Temporary changes because of alterations, repairs, etc. do not affect bed capacity.

6. Line 7
Complete if Lines 5 and 6 are different.

7. Line 8
Compute the total licensed bed days available during the period by multiplying the number of beds available for the period by the number of days in the period. Any increase or decrease in the number of beds must be

taken into consideration as well as the number of days elapsed during each increase or decrease.

8. Line 9
The percentage of occupancy for the cost report period is computed by dividing the total resident days from Line 4.1, Column A by the bed days available on Line 8. The decimal place will be carried out to four places. Example - 92.31%.

9. Line 10
The percentage of Medicaid utilization is computed by dividing the total Medicaid days from Line 4.1, Column B by the total resident days from Line 4.1, Column A. The decimal place will be carried out to four places. Example - 92.31%.

D. Form 4 Resident Day Statistics

1. Section I

A resident day is the period of service for one resident for one day of care. For cost reporting purposes, a day paid is considered a resident day. This means that a paid reserved bed will be counted toward total resident days. Examples of paid reserved beds include resident leave of absences from the facility to the hospital or therapeutic home visit that are paid by any source.

The day of the resident's admission is counted but the day of discharge is not counted as a resident day. When a resident is admitted and discharged on the same day, this period must be counted as one resident day.

a) Column 2
List Medicaid resident days for the reporting period by month. The total of this column must agree with Form 3, Line 4.1, Column B.

b) Column 3
List Medicare resident days for the reporting period by month. The total of this column must agree with Form 3, Line 4.1, Column C.

c) Column 4
List private pay resident days for the reporting period by month. The total of this column must agree with Form 3, Line 4.1, Column D.

d) Column 5
List all other types of resident days for the reporting period by month. The total of this column must agree with Form 3, Line 4.1, Column E.

e) Column 6
Total of Columns 2, 3, 4, and 5. The total of this column must agree with Form 3, Line 4.1, Column A.

f) Column 7
List the total number of bed days available for each month. The total of this column must agree with Form 3, Line 8.

g) Column 8
Divide the Total Resident Days in Column 6 by the Bed Days Available in Column 7 for each line. The "Total" Line for this column must agree with Form 3, Line 9. The decimal place will be carried out to four places. Example - 92.31%.

2. Section II.

List the facility's third party daily rates for both private rooms and semi-private rooms that were effective during the reporting period. The list should include all rates that were effective during the reporting period. Also list the number of resident days by level of care by payor source and room type. The resident days by payor source and room type plus Medicaid days by level of care must equal Form 3, Line 4.2.

E. Form 5 Statement of Revenues

All revenue, regardless of source, is to be entered on the appropriate line in Column 1 on this schedule and should agree with the revenue and adjustment account balances recorded on the submitted adjusted trial balance. As described in Section 3-4, adjustments to specific expenses per revenue amounts can be identified in Column 2 in lieu of determining and eliminating the actual cost. Column 3 is to be used to identify which Form 6 line number is being adjusted if the revenue is used to reduce the expense. Provide a separate detailed schedule for Form 6 line number corresponding adjustment amounts when more than one Form 6 line number is to be adjusted.

1. Line 1, Resident Per Diem/Monthly Rate
Medicaid, Private, Medicare Part A, and other Third Party amounts received and receivable for services/supplies usually reimbursed on a per diem or monthly basis.

2. Line 2, Medicare Part A
Physical Therapy, Occupational Therapy, Speech Therapy, medical supplies and other ancillary services/supplies billed separately to Medicare Part A.

3. Line 3, Medicare Part B
Physical Therapy, Occupational Therapy, Speech Therapy and medical

supplies amounts received and receivable for Medicare Part B reimbursed services.

4. Line 4, Other Third Party Ancillaries (Schedule)
Amounts received and receivable for other ancillary services/supplies/ therapies/medical supplies when paid separately from a resident's all inclusive per diem or monthly payment. Amounts received from the sale of other ancillary supplies/services to employees or other non-residents will be included here. Attach a detail schedule of adjustments made for other third party ancillaries.

5. Line 5, Less: Total Contractual Adjustments, Allowances and Discounts on Patients' Accounts.

6. Line 6, Pharmacy
Amounts received and receivable for drugs and pharmaceuticals from residents, employees or other non-residents.

7. Line 7, Beauty and Barber
Amounts received and receivable for beauty and barber services.

8. Line 8, Contributions, Gifts, Grants, etc.
Amounts received from contributions, gifts, grants, etc.

9. Line 9, Guest and Employee Meals
Amounts received and receivable for guest and employee meals.

10. Line 10, Interest
Interest Income earned per savings accounts, bonds, etc.

11. Line 11, Laundry
Amounts received and receivable for laundry services.

12. Line 12, Personal Items
Amounts received and receivable from the sale of personal items.

13. Line 13, Nurse Aide Training and Testing
Amounts received and receivable for nurse aide training and testing.

14. Line 14, Rental
Amounts received and receivable for rental.

15. Line 15, Television (Resident Rooms)
Amounts received and receivable for television services.

16. Line 16, Telephone
Amounts received and receivable for telephone services.

17. Line 17, Vending Machines
Amounts received and receivable from vending machine sales.

18. Line 18, Criminal Records Check
Amounts received and receivable for criminal records checks.

19. Line 19, Other (Schedule)
Amounts received and receivable for other. Attach a detail schedule of other income items.

20. Line 20, Total Revenue
Sum of Lines 1 through 19.

21. Line 21, Less: Total Operating Expenses
Amount per Form 6, Line 6, Column 1.

22. Line 22, Net Income (Loss) Per Books
Line 20 less Line 21.

23. Line 23, Less: Net Related Party Adjustments
Amount per Form 6, Line 6, Column 3.

24. Line 24, Other Adjustments (Schedule)
Any other necessary adjustments including excess direct compensation as described in Sections 3-2.B. and 3-2.O.

25. Line 25, Adjusted Net Income (Loss)
Line 22 plus/minus Line 23 and 24 adjustments.

F. Form 6 Schedule of Expenses

Column 1 - Enter the expenses per the adjusted trial balance on the appropriate line. Do not net general ledger expenses by omitting from the first column any non-allowable items. Columns 2 and 5 must be used to reclassify or adjust out any non-allowable items. Line 6, Column 1 must agree with Form 5, Line 21.

Column 2 - This column is for any reclassification that should be made between expenses. The total for Column 2 on Line 6 must be zero.

Column 3 - This column is used to make adjustments for related party expenses. Example - to remove unallowable related party rent included on Line 3-09 or 3-10 and record the actual cost of amortization, depreciation, interest, property insurance and property taxes on Lines 3-01, 3-02, 3-03, 3-04, 3-05, 3-06 and 3-08. This column will include the total net adjustments to allowable cost for related management company/home office expense reported on Line 2-50.

Column 4 - Column 1 plus or minus Column 2 and Column 3.

Column 5 - Adjustments to expenses will be entered in Column 5. These adjustments will include Form 5 revenue adjustments and unallowable expenses, etc. This column will include adjustments for excess direct facility compensation as described in Section 3-2.B.

Column 6 - Column 4 plus or minus Column 5 adjustments.

1. Form 6, Section 1 Direct Care Expenses

Line 1-01, Salaries - Aides
Salaries of certified nurse aides and nurse aides in training.

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

Line 1-03, Salaries - RN's (exclude DON and Assistant DON)
Salaries of registered nurses and graduate nurses (excluding the DON and Assistant DON).

Line 1-04, Salaries - Assistant Director of Nursing
Salaries of the Assistant Director of Nursing.

Line 1-05, Salaries - Director of Nursing
Salaries of Director of Nursing.

Line 1-06, Salaries - Occupational Therapists
Salaries of occupational therapists. Therapy costs which are reimbursed by Medicare Part A, Medicare Part B or a third party payer should be reclassified to Line 5-11.

Line 1-07, Salaries - Physical Therapists
Salaries of physical therapists. Therapy costs which are reimbursed by Medicare Part A, Medicare Part B or a third party payer should be reclassified to Line 5-11.

Line 1-08, Salaries - Speech Therapists
Salaries of speech therapists. Therapy costs which are reimbursed by Medicare Part A, Medicare Part B or a third party payer should be reclassified to Line 5-11.

Line 1-09, Salaries - Other Therapists
Salaries of therapists other than occupational therapists, physical therapists and speech therapists. Therapy costs which are reimbursed by Medicare Part A, Medicare Part B or a third party payer should be reclassified to Line 5-11.

Line 1-10, Salaries - Rehabilitation Nurse Aides
Salaries of rehabilitation nurse aides and/or Health Rehabilitative Nurse Aides.

Line 1-11, FICA - Direct Care
Cost of employer's portion of Social Security Tax for direct care employees.

Line 1-12, Group Health - Direct Care
Cost of employer's contribution to employee health insurance for direct care employees.

Line 1-13, Pensions - Direct Care
Cost of employer's contribution to employee pensions for direct care employees.

Line 1-14, Unemployment Taxes - Direct Care
Cost of employer's contribution to State and Federal unemployment taxes for direct care employees.

Line 1-15, Uniform Allowance - Direct Care
Employer's cost of uniform allowance and/or uniforms for direct care employees.

Line 1-16, Worker's Compensation - Direct Care
Cost of worker's compensation insurance for direct care employees.

Line 1-17, Other Fringe Benefits - Direct Care (Schedule)
Cost of other fringe benefits not specifically noted on Line 1-11 through 1-16. A schedule must be attached that details the amount on this line.

Line 1-18, Contract - Aides
Cost of aides hired through contract that are not facility employees.

Line 1-19, Contract - LPN's
Cost of LPN's and graduate practical nurses hired through contract that are not facility employees.

Line 1-20, Contract - RN's
Cost of RN's and graduate nurses hired through contract that are not facility employees.

Line 1-21, Contract - Occupational Therapists
Cost of occupational therapists hired through contract that are not facility employees. Therapy costs, which are reimbursed by Medicare

Part A, Medicare Part B or a third party payer, should be reclassified to Line 5-11.

Line 1-22, Contract - Physical Therapists

Cost of physical therapists hired through contract that are not facility employees. Therapy costs, which are reimbursed by Medicare Part A, Medicare Part B or a third party payer, should be reclassified to Line 5-11.

Line 1-23, Contract - Speech Therapists

Cost of speech therapists hired through contract that are not facility employees. Therapy costs, which are reimbursed by Medicare Part A, Medicare Part B or a third party payer, should be reclassified to Line 5-11.

Line 1-24, Contract - Other Therapists

Cost of therapists other than occupational therapists, physical therapists and speech therapists hired through contract that are not facility employees. Therapy costs, which are reimbursed by Medicare Part A, Medicare Part B or a third party payer, should be reclassified to Line 5-11.

Line 1-25, Consultant Fees - Nursing

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

Line 1-26, Training – Direct Care (Schedule)

Cost of training related to resident care for RN's, LPN's and Certified Nurse Aides. Also includes travel costs associated with this training. Training cost for Nurse Aide certification should be on Line 5-10, non-allowable nurse aide training. A detailed schedule must be submitted that agrees with the amount on this line. The schedule will include for each expenditure the date, description of training, destination, person traveling, expense description, and the cost.

Line 1-27, Over-the-Counter Drugs

Cost of over-the-counter drugs provided by the facility to its residents.

Line 1-28, Oxygen

Cost of oxygen and related supplies.

Line 1-29, Medical Supplies - Direct Care

Cost of resident-specific items of medical supplies such as catheters, syringes, sterile dressings, prep supplies, alcohol pads, Betadine solution in bulk, tongue depressors, cotton balls, thermometers, and blood pressure cuffs. Costs of supplies for which Medicare Part B

revenue is received must be reclassified to Line 5-11 in Column 2 or removed in Column 5 per Form 5 revenue adjustments.

Line 1-30, Therapy Supplies

The cost of supplies used directly by the therapy staff for rendering therapeutic service to the residents of the facility. Costs of therapy supplies for which other third party income is received (Medicare Part A, Medicare Part B, etc.) must be reclassified to Line 5-11 in Column 2 or removed in Column 5 per Form 5 revenue adjustments.

Line 1-31, Raw Food

Cost of food products used to provide meals and snacks to residents.

Line 1-32, Food - Supplements

Cost of food products given in addition to normal meals and snacks under doctor's orders.

Line 1-33, Incontinence Supplies

Cost of incontinence supplies to include diapers and underpads.

Line 1-34, Dental (Schedule)

Cost of dentist advisory services (not individual resident specific). All other dental expenses must be reclassified to Line 5-11 in Column 2. A schedule must be attached that details the amount on this line. For Arkansas Health Center Nursing Facility (AHC), all dental services are allowable.

Line 1-35, Drugs Legend

Cost of prescription drugs are allowable only for AHC. Other nursing facilities must reclassify these costs to Line 5-11 in Column 2.

Line 1-36, Lab and X-Ray

Cost of lab and x-ray services are allowable only for AHC. Other nursing facilities must reclassify these costs to Line 5-11 in Column 2.

Line 1-37, Total Direct Care Costs

Line 1-37 is the sum of Line 1-01 through Line 1-36.

2. Form 6, Section 2 Indirect, Administrative and Operating Cost

Line 2-01, Salaries - Administrator

Salaries of licensed administrators excluding owners.

Line 2-02, Salaries - Assistant Administrator

Salaries of licensed assistant administrators excluding owners.

Line 2-03, Salaries - Dietary

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

Line 2-04, Salaries - Housekeeping

Salaries of housekeeping personnel including housekeeping supervisors and staff.

Line 2-05, Salaries - Laundry

Salaries of laundry personnel including laundry supervisor and staff.

Line 2-06, Salaries - Maintenance

Salaries of personnel involved in operating and maintaining the physical plant, including maintenance supervisor and staff.

Line 2-07, Salaries - Medical Records

Salaries of medical records personnel.

Line 2-08, Salaries - Other Administrative

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

Line 2-09, Salaries - Activities

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

Line 2-10, Salaries - Pharmacy

Salaries of pharmacy employees (AHC only).

Line 2-11, Salaries - Social Services

Salaries of personnel providing medically related social services to attain or maintain the highest practicable physical, mental or psychosocial well being of the residents.

Line 2-12, Salaries - Owner or Owner/Administrator

Salaries of all owners of the facility.

Line 2-13, FICA - Indirect, Administrative and Operating

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

Line 2-14, Group Health - Indirect, Administrative and Operating

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

Line 2-15, Pensions - Indirect, Administrative and Operating
Cost of employer's contribution to employee pensions for administration and operating employees.

Line 2-16, Unemployment Taxes - Indirect, Administrative and Operating
Cost of employer's contribution to State and Federal unemployment taxes for administration and operating employees.

Line 2-17, Uniform Allowance - Indirect, Administrative and Operating
Employer's cost of uniform allowance and/or uniforms for administration and operating employees.

Line 2-18, Worker's Comp - Indirect, Administrative and Operating
Cost of worker's compensation insurance for administration and operating employees.

Line 2-19, Other Fringe Benefits - Indirect, Administrative & Operating (Schedule)
Cost of other fringe benefits not specifically noted on Line 2-13 through 2-18. A schedule must be attached that details the amount on this line.

Line 2-20, Contract - Dietary
Cost of dietary services and personnel hired through contract that are not facility employees.

Line 2-21, Contract - Housekeeping
Cost of housekeeping services and personnel hired through contract that are not facility employees.

Line 2-22, Contract - Laundry
Cost of laundry services and personnel hired through contract that are not facility employees.

Line 2-23, Contract - Maintenance
Cost of maintenance services and personnel hired through contract that are not facility employees.

Line 2-24, Consultant Fees - Dietitian
Fees paid to consulting registered dietitians.

Line 2-25, Consultant Fees - Medical Records
Fees paid to consulting Accredited Records Technicians or Medical Records Administrators.

Line 2-26, Consultant Fees - Activities

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

Line 2-27, Consultant Fees - Medical Director

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

Line 2-28, Consultant Fees - Pharmacy

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

Line 2-29, Consultant Fees - Social Worker

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

Line 2-30, Consultant Fees - Therapists

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

Line 2-31, Barber and Beauty Expense - Allowable

The cost of barber and beauty services provided to residents by facility staff.

Line 2-32, Transportation

In lieu of actual costs, the facility may report on this line allowable amounts claimed (rate per mile) for facility owned or other vehicles used in providing residents medical transportation to local "community" providers or used for business related mileage (as described in Section 3-2.K).

This line should also include cost of providing residents medical transportation to local "community" providers when the facility obtains this service from an outside source.

Line 2-33, Resident Activities

Cost of resident activities should include pastoral services, recreational activities and supplies.

Line 2-34, Care Related Supplies

The cost of supplies used by the care related staff for rendering care related services to the residents of the facility including personal hygiene items such as shampoo and soap.

Line 2-35, Accounting Fees

Fees incurred for the preparation of the cost report, audits of the

financial records, bookkeeping services, tax return preparation of the nursing facility and other related services, excluding personal tax planning and personal tax return preparation.

Line 2-36, Advertising for Labor/Supplies
Allowable advertising expense.

Line 2-37, Amortization Expense - Non-Capital (Schedule)
Costs incurred for legal and other expenses when organizing a corporation should be amortized over a period of 60 months. Attach a detail amortization schedule for these costs. These costs are not to be included on the Form 7 depreciation schedule.

Line 2-38, Bank Service Charges
Fees paid to banks for service charges, excluding penalties and insufficient funds charges.

Line 2-39, Criminal Records Checks
Cost of Criminal Records Checks for employees and job applicants.

Line 2-40, Data Processing Fees
Cost of purchased services for data processing systems and services.

Line 2-41, Dietary Supplies
Costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc. used in the dietary department.

Line 2-42, Dues (Schedule)
A detailed schedule of dues must be included. The schedule should include the dates and purpose covered by the charge.

Line 2-43, Educational Seminars and Training
The cost of registration for attending non-direct care related educational seminars and training by employees of the facility and costs incurred in the provision of non-direct care related in-house training for facility staff. The cost of any travel incurred to attend an educational seminar will be included on Line 2-56, Travel.

Line 2-44, Governing Body (Schedule)
Costs incurred by members of the facility governing body to attend meetings. Attach a detail schedule of the members' names and costs incurred.

Line 2-45, Housekeeping Supplies
Cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

Line 2-46, Laundry Supplies

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

Line 2-47, Legal Fees (Schedule)

Fees paid to attorneys in accordance with other provisions of the State Plan. A schedule must be attached that details the amount on this line.

Line 2-48, Linen and Laundry Alternatives

Cost of sheets, blankets, pillows, and gowns.

Line 2-49, Miscellaneous (Schedule)

Costs incurred in providing nursing facility services that cannot be assigned to any other line item on Form 6. A schedule must be attached that details the amount on this line.

Line 2-50, Management Fees and Home Office Costs

The cost of purchased management services or home office costs incurred that are allocable to the provider. See Form 15 for calculation of allowable home office costs.

Line 2-51, Office Supplies and Subscriptions

Cost of consumable goods used in the business office such as pencils, paper, and computer supplies. Cost of printing forms and stationary including accounting and census forms, charge tickets, facility letterhead and billing forms. Cost of subscribing to newspapers, magazines and periodicals.

Line 2-52, Postage

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

Line 2-53, Repairs and Maintenance

Supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair the facility building, furniture, equipment and vehicles.

Line 2-54, Taxes - Other (Schedule)

The cost of taxes paid that are not included on any other line on Form 6. A schedule must be attached to the cost report in order for the costs to be considered in the determination of allowable costs.

Line 2-55, Telephone and Communications

Cost of telephone services, WATS lines and FAX services.

Line 2-56, Travel (Schedule)

Cost of travel (airfare, lodging, meals, etc.) by Administrator and other authorized personnel to attend professional and continuing educational seminars and meetings related to their position within the facility. A detailed schedule must be submitted that agrees with the amount on this line. The schedule will include for each expenditure the date, destination, person traveling, purpose of the trip, expense description, and the cost.

Line 2-57, Utilities

Cost of water, sewer, gas, electric, and garbage collection services. Cost of television and cable services for common use areas in the facility.

Line 2-58, Depreciation – Vehicles and Software

Depreciation on the facility's vehicles and software. Column 6 of Line 2-58 must agree with Form 7, Page 3, Vehicle Depreciation line, Column 5 and Form 7, Page 3, Software Depreciation line, Column 5.

Line 2-59, Interest – Working Capital, Vehicles and Software

Interest paid on short term borrowing for facility operations. Also, interest paid or accrued on loans, the proceeds of which were used to purchase vehicles or software. The total of Line 2-59, Column 6, must agree with the Form 10, Page 3, Totals Column, Line 12.

Line 2-60, Total Indirect, Administrative and Operating Costs

Line 2-60 is the sum of Line 2-01 through Line 2-59.

3. Form 6, Section 3 Property

Amounts for depreciation, Rent – Building and Rent – Furniture and Equipment must be identified for historical purposes only. A Fair Market Rental Payment is made in lieu of these expenses.

Line 3-01, Amortization Expense - Capital (Schedule)

Legal and other costs incurred when financing the facility should be amortized over the life of the mortgage. Attach a detail amortization schedule for these costs. These costs are not to be included on the Form 7 depreciation schedule.

Line 3-02, Depreciation – Fair Market Rental

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. Items costing $300 or more will be capitalized.

Line 3-03, Depreciation – Generator

Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.

Line 3-04, Interest Expense – Fair Market Rental

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to finance the fixed assets or major movable equipment. The total of Line 3-04, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 10.

Line 3-05, Interest Expense – Generator

Interest paid or accrued on notes the proceeds of which were used to purchase a generator approved by the Office of Long Term Care under Act 1602 of 2001. The total of Line 3-05, Column 6 must agree with the Form 10, Page 3, Totals Column, Line 11.

Line 3-06, Property Insurance

Cost of fire and casualty insurance on facility buildings and equipment.

Line 3-07, Professional Liability Insurance

Cost of insuring the facility against injury and malpractice claims.

Line 3-08, Property Taxes

Taxes levied on the facility's land, buildings, furniture and equipment.

Line 3-09, Rent - Building

Cost of leasing the facility's real property.

Line 3-10, Rent - Furniture and Equipment

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

Line 3-11, Total Property

Line 3-11 is the sum of Line 3-01 through Line 3-10.

4. Form 6, Section 4 Quality Assurance Fee

Cost of the quality assurance fee paid monthly to the Department Human Services.

5. Form 6, Section 5 Non-Allowable Costs

Line 5-01, Advertising

Costs of unallowable advertising.

Line 5-02, Bad Debts

Accounts receivable written off as uncollectable.

Line 5-03, Barber and Beauty Expense

The cost of barber and beauty services provided by non-facility personnel.

Line 5-04, Contributions

Amounts donated to charitable or other organizations.

Line 5-05, Depreciation Over Straight Line

Depreciation charged above straight line. Amounts posted to this line should result from reclassifications (Column 2) from Line 3-02. Column 1 should equal zero.

Line 5-06, Income Taxes - State and Federal

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

Line 5-07, Insurance - Officers

Cost of unallowable life insurance on officers and key employees of the facility per Section 3-3.T.

Line 5-08, Non-Working Officer's Salaries

Salaries and other compensation paid to non-working officers.

Line 5-09 and 5-10, Nurse Aide Testing and Training

Costs incurred in having nurse aides tested or trained in order to meet OBRA 1987 provisions. This includes both the Medicaid and non-Medicaid portion of the expenses. Example - A nursing facility incurs $1,000 in allowable expenses for nurse aide training. A bill is submitted to the Division of Medical Services for direct reimbursement. Based on the facility's percentage of Medicaid utilization, the facility was eligible for 80% reimbursement. A payment was made to the facility in the amount of $800 ($1,000 X 80%) for the Medicaid portion of the nurse aide training expense. The $1,000 should be included in non-allowable costs and the $800 reimbursement should be included on Form 5, Line 13. The same principles apply to Nurse Aide Testing Costs and reimbursements from the contracted testing company.

Line 5-11, Other Non-Allowable Costs

Other costs that are considered non-allowable in accordance with other provisions of the State Plan (products sold to residents, etc.).

Line 5-12, Penalties & Sanctions

Includes by way of illustration, penalties and sanctions assessed by the Division of Medical Services, the Internal Revenue Service, the

State Tax Commission, or financial institutions (i.e., insufficient funds charges).

Line 5-13, Television & Cable (Resident Rooms)
Cost of television sets used in the residents' rooms or for providing cable TV to the residents' rooms.

Line 5-14, Vending Machines
Cost of items sold to employees, residents and the general public including candy bars and soft drinks.

Line 5-15, Goodwill
Amortization of Goodwill costs. These costs are not to be included on the Form 7 depreciation schedule.

Line 5-16, Total Non-Allowable Costs
Line 5-16 is the sum of Line 5-01 through Line 5-15.

6. Form 6, Section 6 Total Costs

Line 6, Total Costs
Line 6, is the total of 1-37, 2-60, 3-11, 4, and 5-16. Column 1 must agree with the total expenses in the adjusted trial balance.

7. Form 6, Page 8 Computation of Cost per Day

Line 7, Total Resident Days
Enter the number of total resident days from Form 3, Line 4.1, Column A.

Line 8, Direct Care Costs
Enter in Column A, the cost from Line 1-37, Column 6. Column B (Direct Care cost per day) is calculated by dividing Line 8, Column A by Line 7.

Line 9, Indirect, Administrative and Operating Costs
Enter in Column A, the cost from Line 2-60, Column 6. Column B (Indirect, Administrative and Operating cost per day) is calculated by dividing Line 9, Column A by Line 7.

Line 10, Property Costs
Enter in Column A, the cost from Line 3-11, Column 6. Column B

(Property cost per day) is calculated by dividing Line 10, Column A by Line 7.

Line 11, Quality Assurance Fee

Enter in Column A, the cost from Line 4, Column 6. Column B (Quality Assurance Fee cost per day) is calculated by dividing Line 11, Column A by Line 7.

Line 12, Total Costs

Line 12, Column A is the total of Lines 8, 9, 10 and 11, Column A. This total should agree with Line 6, Column 6. Total Per Diem Cost is calculated by dividing Line 12, Column A by Line 7.

G. Form 7 Schedule of Fixed Assets and Depreciation

Depreciation expense will be reported on Form 7, Pages 1, 2, and 3 by asset category/description. Pages 1 and 2 are to be used to report separately the depreciation expense incurred for facility owned assets (Page 1) and the depreciation expense incurred for related party owned assets (Page 2). All assets must be reported on these two pages. Page 3 is to be completed by adding Page 1 and Page 2 together. A copy of the facility's depreciation schedule must be attached to the cost report and should identify and reconcile with amounts posted to Form 7, Page 1 by asset category. A separate depreciation schedule for the related party assets reported on Page 2 must also be attached and should identify and reconcile with amounts posted to Form 7, Page 2 by asset category. The depreciation schedule(s) must be completed using the straight-line method and will reflect the same period as the cost report and will include the asset description, acquisition date, historical cost, salvage value if used, depreciable base, useful life, cost report period, depreciation expense claimed, and accumulated depreciation to date. Straight-line depreciation is the only method allowable for cost reporting purposes.

Assets purchased (not leased) from related parties will be included on Page 1 but are subject to related party cost limits identified in Section 3-1.F.2. These assets should be included in Column 1 of Page 1, but adjusted to the related party allowable amounts per Column 4 adjustments.

For Nursing Facilities which are combined with/attached to other operations (hospitals, RCF's, etc.), assets used only by these other operations should not be included on Form 7, Columns 1 through 5. Common used assets should be included on Form 7, Columns 1 through 5, but only for the amounts allocated to the Nursing Facility. Copies of workpapers/schedules used to make these allocations must be attached to Form 7 and the depreciation schedules. These workpapers/schedules will identify the common assets used, allocated amounts, descriptions and allocation methods used.

All vehicles and generators approved by the Office of Long Term Care under Act

1602 of 2001 must be listed separately on their designated Form 7 line. Vehicle depreciation is subject to the limits identified in Section 3-2 K.2.

1. Description of Property

   a) Historical Cost - Column 1
   Enter the actual cost of the assets. The facility owned asset amounts reported on Form 7, Page 1 must agree with the facility's adjusted trial balance recorded asset amounts.

   b) Ending Accumulated Depreciation - Column 2
   The total accumulated depreciation calculated using the straight-line method will be reported in this column.

   c) Depreciation Expense - Column 3
   The depreciation expense using the straight-line method will be reported in this column. The total of this column on Form 7, Page 1 plus any amount reclassified to Form 6, Line 5-05 (Depreciation over straight-line), Column 2 will agree with the total depreciation posted to the adjusted trial balance per Form 6, Line 2-58, Column 1, Line 3-02, Column 1 and Line 3-03, Column 1.

   d) Other Adjustments (Schedule) – Column 4
   Use this column to record adjustments for unallowable vehicles, allocated unallowable vehicles per usage, mobile homes, RV's, etc. Use this column also to record adjustments to depreciation expense for gains or losses from the sale/disposal of assets. The total of the adjustments in this column will agree with adjustments reported on Form 6, Lines 2-58, 3-02, and 3-03 Column 5. A schedule must be attached that details the adjustment amounts.

   e) Facility Related Depreciation - Column 5
   Column 3 plus or minus Column 4 adjustments.

2. After Form 7, Pages 1, 2, and 3 are complete,

   a) Form 7, Page 3, Column 3 (Total) will equal to Form 6, Lines 2-58, 3-02 and 3-03, Column 4.

   b) Form 7, Page 3, Column 4 (Total) will equal to Form 6, Lines 2-58, 3-02 and 3-03, Column 5.

   c) Form 7, Page 3, Column 5 (Total) will equal to Form 6, Lines 2-58, 3-02 and 3-03, Column 6.

3. Any Assets included on Form 7, Page 1 that are not related to resident care must be identified on the bottom of Form 7, Page 1.

H. Form 8 Facility Transactions with Related Organizations

1. Section I.

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

2. Section II.

Identify those costs that contain expenditures for services or supplies furnished to the facility by related organizations per Section 3-1.F.2. Indicate the form number and line number to designate the location of the expense. Provide the name of the related organization, the amount of current year transactions, the cost to the related organization, and the amount of the transactions in excess of cost. The amount of transactions in excess of cost must be transferred to the appropriate line on Form 6 as an adjustment in Column 3. For example, if a facility purchased services or supplies from a related organization for $500 and the cost of those services or supplies to the related organization was $300, the excess over cost, or $200, must be transferred to the appropriate line on Form 6 as a Column 3 adjustment to offset the expense.

Adjustments to expenses will be made to the appropriate line on Form 6, Column 3 for all related party expense adjustments. For related party lease agreements, unallowable lease costs should be removed in total on Lines 3-09 and 3-10, and the actual cost of amortization, depreciation, interest, property insurance and property taxes should be posted to Lines 3-01, 3-02, 3-03, 3-04, 3-05, 3-06 and 3-08, Column 3 respectively. See also instructions for reporting related party depreciation and related party interest per Form 7 and Form 10.

Interest income from related organizations will be transferred to Form 5, Line 10, Column 2. Form 6 interest expense can not be reduced to below zero.

3. Section III.

List the name of each owner of the facility and their relationship with organizations described in Section II.

I. Form 9 Rental of Property, Plant, and Equipment

List any leases pertaining to buildings, furniture, and equipment. Identify the lessor, the leased item, the terms of the lease including the amount of the monthly payment,

a description of the purchase option, if any, and the amount of rent applicable to the current reporting period.

J. Form 10 Analysis of Interest Bearing Debt and Related Interest Expense

1. All interest bearing debt must be reported on Form 10, Pages 1 and 2. These two forms are to be used to report separately the interest expense incurred by the facility on Page 1 and allowable interest expense incurred by a related party on Page 2. Each note should be listed under the columns for Notes 1-11 with the total listed in Column 12. If the facility had more than eleven notes payable during the reporting period, please attach an additional Form 10. Form 10, Page 3 is to be completed by adding the Total columns from Form 10, Pages 1 and 2, Lines 2, 3, 4, 5, 6, 10, 11, 12 and 13.

   a) Line 1, Lender
   Report the lender's name.

   b) Line 2, Original Loan Amount
   Report the total amount financed at the loan's origination.

   c) Line 3, Beginning Balance
   Balance at the beginning of the cost reporting period. The Page 1 total of the Beginning Balance line must agree with the payable amounts reported in Column 1 of Form 11.

   d) Line 4, Ending Balance
   Balance at the end of the reporting period. The Page 1 total of the Ending Balance line must agree with the payable amounts reported in Column 2 of Form 11.

   e) Line 5, Current Portion
   The current portion of interest bearing debt. The portion due within one year should be reported in this column for all interest bearing debt. The Page 1 total of this line must agree with the amount on Form 11, Line 23, Column 2.

   f) Line 6, Long-Term Portion
   The non-current portion of long-term notes payable should be reported in this column. The Page 1 total must agree with Form 11, Line 33.

   g) Line 7, Terms of Debt
   Describe the terms of the debt.

   h) Line 8, Asset Financed
   Describe the asset financed or purpose of the loan. For example,

mortgage of building, purchase of equipment, working capital, vehicle, software, etc.

i) Line 9, Interest Rate
List the interest rate.

j) Line 10, Allowable Interest – Fair Market Rental
Report the allowable interest expense for Fair Market Rental payment for the cost reporting period.

k) Line 11, Allowable Interest - Generator
Report the allowable interest expense for generator for the cost reporting period.

m) Line 12, Allowable Interest – Working Capital & Other
Report the allowable working capital interest expense for the cost reporting period. Also report the allowable interest expense on other items such as vehicles and software.

n) Line 13, Non-Allowable Interest
Report the non-allowable interest expense for the cost reporting period.

2. After Form 10, Pages 1, 2, and 3 are complete,

a) Form 10, Page 1, Column 12, Line 10 will agree with Form 6, Line 3-04, Column 1. Form 10, Page 1, Column 12, Line 11 will agree with Form 6, Line 3-05, Column 1. Form 10, Page 1, Column 12, Line 12 will agree with Form 6, Line 2-59, Column 1. Form 10, Page 1, Column 12, Line 13 will agree with Form 6, Line 5-11, Column 1 (unallowable interest only).

b) Form 10, Page 2, Column 12, Line 10 will agree with Form 6, Line 3-04, Column 3. Form 10, Page 2, Column 12, Line 11 will agree with Form 6, Line 3-05, Column 3. Form 10, Page 2, Column 12, Line 12 will agree with Form 6, Line 2-59, Column 3.

c) Form 10, Page 3, Column 12, Line 10 will agree with Form 6, Line 3-04, Column 6. Form 10, Page 3, Column 12, Line 11 will agree with Form 6, Line 3-05, Column 6. Form 10, Page 3, Column 12, Line 12 will agree with Form 6, Lines 2-59, Column 6.

K. Form 11 Balance Sheet

The balance sheet as of the beginning of the reporting period is reported in Column 1

and the balance sheet as of the end of the reporting period is reported in Column 2. Note: Column 1 of this report must equal Column 2 of the previous cost report.

1. Line 1, Cash on Hand & In Banks
   Cash on Hand & in Banks includes all funds actually on hand or in bank accounts subject to immediate withdrawal.

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

3. Line 3, Less Allowance for Uncollectable Accounts
   Allowance for Uncollectable Accounts includes the estimated loss for accounts receivable that will not be collected.

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

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

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

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

8. Line 8, Inventory
   Inventory includes those goods awaiting sale or use, and excludes those long-term assets subject to depreciation. Inventories are normally conservatively valued at the lower of "cost or market". List the method of inventory valuation in the space provided. Examples of inventory items include dietary supplies, housekeeping supplies and linens.

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

10. Line 10, Investments
Investments are normally permanent or long-term securities with value, but which are normally not available for immediate withdrawal. Investments include stock and bonds, certificates of deposit, etc.

11. Line 11, Other Current Assets
Other Current Assets include all current assets which are not appropriately included on any other line of the balance sheet.

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

13. Line 13, Property, Plant and Equipment
Property, Plant and Equipment must agree with the total of all assets recorded on Form 7, Page 1, Column 1.

14. Line 14, Less Accumulated Depreciation
Less Accumulated Depreciation represents a reduction of the property, plant, and equipment reported on Line 13. The amount entered in the beginning column reports accumulated depreciation at the beginning of the reporting period, and therefore, does not include the depreciation expense for this period.

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

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

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

18. Line 18, Deposits (Schedule)
Deposits include amounts used to secure accounts with utility companies, for workers compensation insurance or with lessors, for example. A schedule must be attached that details the amount on this line.

19. Line 19, Other Noncurrent Assets
Other Noncurrent Assets represent those non-current assets which are not appropriately reported on any other line (ex. organization costs).

20. Line 20, Total Other Assets
Total Other Assets is the sum of amounts recorded on Lines 16 through 19.

21. Line 21, Total Assets
Total Assets represents the sum of amounts recorded on Lines 12, 15, and 20 of the balance sheet.

22. Line 22, Accounts Payable
Accounts Payable represent liabilities of daily transactions normally kept on open account for goods and services purchased. Exclude accounts payable owed to related parties.

23. Line 23, Notes Payable and Current Portion of Long Term Debt
Notes Payable and Current Portion of Long-Term Debt includes obligations that are scheduled to mature within one year after the balance sheet date and the current portion of long-term debt.

24. Line 24, Accrued Salaries
Accrued Salaries represent the salaries and wages earned by employees but not paid during the accounting period. To be recognized as an allowable expense, salaries accrued at the end of the accounting year must be paid within ninety days of the year end.

25. Line 25, Accrued Payroll Taxes
Accrued Payroll Taxes include undeposited federal and state income and FICA taxes withheld. It also includes union dues and insurance withheld and the employers' liability for FICA and unemployment taxes.

26. Line 26, Accrued Income Taxes
Accrued Income Taxes include any liability the facility has for federal and state income taxes.

27. Line 27, Inter-Company Payables
Inter-company Payables represent amounts owed by the facility to a home office or other nursing home facility in a multi-facility operation.

28. Line 28, Other Current Liabilities
Other Current Liabilities represent any current obligations not included elsewhere on Form 11, Lines 22-27. A schedule must be included with the cost report.

29. Line 29, Total Current Liabilities
Total Current Liabilities represents the sum of amounts reported on Lines 22 through 28 of this form.

30. Line 30, Mortgage Payable
Mortgage Payable represents the mortgage obligation that is scheduled to mature after one year from the balance sheet date.

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

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

33. Line 33, Total Long-Term Liabilities
Total Long-Term Liabilities represents the sum of Lines 30 through 32.

34. Line 34, Total Liabilities
Total Liabilities is the sum of current liabilities (Line 29) and long-term liabilities (Line 33).

35. Lines 35 - 41, Capital
Capital has sections, which apply to proprietorships, partnerships, governmental facilities, and corporations. Only the applicable lines should be completed.

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

37. Line 43, Total Liabilities and Capital
Total Liabilities and Capital is the sum of Total Liabilities (Line 34) and Total Capital (Line 42). Total Liabilities and Capital should agree with Total Assets (Line 21) of the balance sheet.

L. Form 12 Capital Reconciliation

1. Total Capital at Beginning of Period should be obtained from Form 11, Line 42, Column 1.

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

a) Line 1, Net Income (Loss) for Period
Net Income (Loss) for Period is obtained from Form 5, Line 22.

b) Line 2, Contributions to Capital
Contributions to capital must be listed together with the date the contribution was made.

c) Lines 3 and 4
List any other additions to capital.

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

a) Line 1, Dividends Paid
Dividends include those dividends declared during the cost reporting period.

b) Line 2, Owners' or Partners' Withdrawals
Owners' or Partners' Withdrawal must be listed on the lines provided together with the date the withdrawal was made. A schedule must be attached if necessary.

c) Lines 3 and 4
List any other reductions to capital.

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

M. Form 13 Owners' Compensation

A separate Form 13 must be completed for each owner, partner or stockholder listed on Form 14. Additional copies of Form 13 should be made as needed. Compensation other than salary should be specified under other compensation. Examples of such compensation are given on Form 13. Each completed Form 13 must be signed by the owner, partner or stockholder.

The Section I "Compensation Paid by Facility" will identify net allowable compensation claimed after adjustments per Column 6 of the applicable Form 6 reported line number.

The Section I "Compensation Paid by Related Management Company/Home Office" will identify net allowable compensation claimed for this facility after adjustments and included on Form 6, Line 2-50, Column 6. This is the allocated/applicable owner's, partner's or stockholder's allowable compensation amount included from Form 15, Line 2-01, Column 6 plus any direct Form 15, Line 2-01, Column 3 compensation.

The Section VII "Analysis of Compensation Paid to Relatives of Owner/Partner/Stockholder" will identify the Form 6 line number in which the compensation is claimed and the total compensation paid to each relative per line number. For relatives of related management company/home office owners, partners or stockholders, the total compensation paid by the related management company/home office to each relative will be identified here per Line 2-50.

N. Form 14 Disclosure of Ownership

Each provider is required to complete the applicable section of this form. All

owners, partners, major stockholders, and officers will be identified on this Form.

The "Direct Compensation from Facility" column will identify direct total compensation amounts paid by the facility. This column will include each owner's, partner's, major stockholder's and officer's total compensation amount as posted from the trial balance to Form 6, Column 1 (do not include Form 6, Line 2-50 amounts for related management company/home office). The "Form 15 Compensation Amount" column will identify the total compensation amount paid to each related management company/home office owner, partner, major stockholder and officer as posted to Form 15, Column 1.

O. Form 15 Home Office or Related Management Company Cost Report Expense Allocation Summary

Each provider that reports expense on Form 6, Line 2-50 as a result of home office costs or management fees paid to a related management company must complete Form 15. The form is to be used to report the allocation of indirectly related expenses as well as directly related expenses from the home office or related management company.

1. Section 1 - Revenue

This section must include the total revenue of the home office or related management company. Facilities should complete only Columns 1 and 2 in Section 1.

2. Section 2 - Expenditures

Line 2-01 through 2-30 will be used to report the expenses for the described accounts. All expense accounts that are not listed in Section 2 must be reported on Line 2-28, Other, and a detailed schedule must be attached to the cost report.

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

b) Column 2
This column is for adjustments for expenses not related to resident care or to offset revenues against expenses. This column will also be used to make necessary adjustments for excess compensation to Line 2-01 as described in Section 3-2.E.

c) Column 3
Expenses that are directly related to the management of the facility for which the cost report is being filed must be reported in Column 3.

d) Column 4
Expenses, which are directly related to the management of all other facilities, must be reported in Column 4.

e) Column 5
Column 1, less Column 2, less Column 3, less Column 4 will be reported in Column 5. These are the expenses to be allocated to all facilities managed by the home office or the management company.

f) Column 6
Column 5 multiplied by the allocation percentage related to the facility for which the cost report is being filed will be reported in Column 6.

3. Section 3 - Calculation of Allowable Expenditures

a) Line 3-01, Expenditures Directly Related to the Facility
The total of expenses directly related to this facility from Line 2-31, Column 3 are reported here.

b) Line 3-02, Expenditures Allocated to this Facility
The total amount of this facility's allocated portion of the indirectly related expenses from Line 2-31, Column 6 are reported here.

c) Line 3-03, Less: Nonallowable Expenses
Nonallowable expenses that are included in Section 2 will be listed by the following categories: Bad Debts, Contributions, Income Tax, Vehicles, and Other. Other nonallowable expenses must be listed on a schedule attached to the cost report.

d) Line 3-04, Total Allowable Expenditures
Total of Lines 3-01, 3-02, and 3-03.

4. Section 4 - Description of Allocation Methods

This section is to be used to describe the methodology used to allocate home office or related management company expenditures to this facility. See Section 3-2.E for instructions concerning allowable cost allocation methods.

P. Form 16 Staffing and Salary Costs

Form 16 must be completed for each facility.

1. Column 2, Salaries Cost
This column must equal the amount on Form 6, Column 1 for the line recorded in column 1.

2. Column 3, Actual Hours
This column is used to record the actual hours paid during the report period for each staff classification.

4. Column 4, Beginning Hourly Rate
This column is used to record the facility's beginning hourly rate for each staff classification as of the ending date of the report period.

4-4A Chart of Accounts

CASH	ACCOUNT NAME	ACCOUNT DESCRIPTION
110.00	Cash in Bank - General	Cash on deposit in a checking account at a bank.
111.00	Cash in Bank - Payroll	Cash on deposit in a checking account used for payroll purposes only. The balance in this account is usually offset by payables for payroll and withholding.
114.00	Cash in Bank - Savings	Cash on deposit in bank or Savings and Loan earning interest income.
116.00	Resident Trust	Funds left with the facility by residents for safekeeping, which is either as cash on hand or in a checking/savings account on deposit.
118.00	Petty Cash	Amount of cash retained on the premises to meet the daily requirements for small purchases or to make change for residents and visitors.
ACCOUNTS RECEIVABLE		
120.00	Private	Amounts due from self-pay residents and other Third Parties.
121.00	Medicare – Part A	Amounts billed to the Medicare Title XVIII fiscal intermediary for SNF services.
122.00	Medicare – Part B	Amounts billed to the Medicare Title XVIII fiscal intermediary for Part B services.
122.10	Medicare Coinsurance/Deductible	Amounts billed to the resident or third party for coinsurance or deductible for Medicare services.
123.00	Medicaid	Amounts due from the Department of Human Services (DHS) for services provided to Medicaid residents.
123.10	Medicaid Resident Liability	Amounts due from the Medicaid resident or third party for his care as established by the local DHS county office.
124.00	Nurse Aide Training & Testing	Amounts due from Medicaid/Medicare/ Private Pay/etc. for Nurse Aide Training and/or Testing.
130.00	Allowance for Doubtful Accounts	Estimate of accounts receivable which will not be collected.
INVENTORY		
135.00	Nursing Supplies	The value of supplies on hand used for the professional care of the resident (i.e., medical and nursing supplies).
136.00	Food	The value of food and food items on hand.
137.00	Food Supplements	The value of food supplements such as Ensure, etc. on hand.
138.00	Linen	The value of sheets, blankets, pillow cases and gowns on hand.

139.00	Incontinence Supplies	The value of incontinence supplies such as diapers and underpads on hand.

PREPAID EXPENSES

145.00	Insurance	Insurance Premiums paid in a current period that apply to coverage in a future period.
146.00	Real Estate Taxes	Real estate taxes paid in advance which apply to future cost reporting periods.
147.00	Personal Property Taxes	Taxes levied on furniture and equipment, which are paid and applied to future cost reporting periods.

FIXED ASSETS

151.00	Land - Nursing Home	Cost of land that is used as the site of the facility building.
152.00	Land Improvements	Cost of paving, parking lot improvements, lighting standards, shrubs or other land improvements not attached to the building. These assets will be included with Buildings and Improvements on the Form 7 Depreciation Schedule.
155.00	Buildings	The cost of buildings and attached assets (central heat/air, carpeting, etc.) used in providing resident care.
156.00	Building Improvements	The cost of remodeling done to building used in providing resident care.
160.00	Equipment	Movable equipment costing $300 or more, e.g., beds, ovens, freezers, typewriters, computers, desks, etc.
161.00	Software	Cost of software owned by the facility.
164.00	Vehicles	Cost of automotive vehicles owned by the facility.
166.00	Leasehold Improvements	The cost incurred by the facility for improvements on rented or leased property used for resident care.

ACCUMULATED DEPRECIATION

170.00	Accumulated Depreciation	Depreciation expense taken during the current period as well as prior years on the above assets.

OTHER ASSETS

181.00	Deposits – Utilities	Amounts on deposit as security with utility companies.
182.00	Deposits – Leases	Amounts on deposit (or last month's rent paid at the beginning of a lease with lessor as security.
183.00	Organization Costs	Net costs incurred in formation of the business the benefits of which will be received over future periods.

184.00	Goodwill	Difference, recorded on the books of the purchaser, of the excess purchase price over the book value of the net tangible assets of an acquired operating entity. Includes any amounts paid to the seller for the permit of approval licensure, covenants not to compete, etc.

CURRENT LIABILITIES

201.00	Accounts Payable	Amounts due to suppliers for services rendered or supplies received.
205.00	Payroll Payable	Payroll amounts due to employees, not yet paid.
206.00	Current Portion of Long Term Debt	Amounts owed for long term debt for the current period, not yet paid.
207.00	Resident's Deposits	Amounts owed to residents for funds left with the facility for safekeeping.

PAYROLL TAX WITHHELD

221.00	Federal Income Tax	Amount of Federal Income Tax withheld from employee's gross pay, not yet remitted.
222.00	FICA (Social Security)	FICA withheld from employee's gross pay, not yet remitted.
223.00	State Income Tax	Amount of State Income Tax withheld from employee's gross pay, not yet remitted.
226.00	Union Dues	Amount of union dues withheld from employee's gross pay.
227.00	Insurance	Amount of insurance premiums withheld from employee's gross pay.

ACCRUED PAYROLL TAXES

230.00	FICA	Social Security taxes owed by employer in addition to those withheld from employees pay.
231.00	Unemployment Taxes	Unemployment Insurance payroll taxes owed by the employer.
235.00	Worker’s Comp	Worker’s Compensation premiums owed by the employer.

OTHER TAXES

241.00	Real Property Tax	Amount owed for taxes levied upon the real property (land and buildings) owned by the facility.
242.00	Personal Property Tax	Amount owed for taxes levied upon the personal property (furniture and equipment) owned by the facility.
243.00	Federal Income Tax	Amount due to Federal Government for taxes levied by it on the net income of the facility.

244.00	State Income Tax	Amount due to the state for taxes levied by it on the net income of the facility.
245.00	Sales Tax	Taxes, passed on to the customers or residents, levied on the retail sale of the facility, which are owed by the facility to state and local governments.
CONTRACTUAL OBLIGATIONS		Amount due to a third party, which is usually made as a result of an agreement to accept cost as payment to a contracting agent.
253.00	Medicare	Amount due to Medicare fiscal intermediary based on cost settlement.
255.00	Medicaid	Amount due to the Department of Human Services.
LONG TERM LIABILITIES		
261.00	Mortgage Payable	Amount due on mortgages, against the facility's real property and improvements owned, with term longer than one year.
263.00	Notes Payable	Amount due on secured notes payable with term longer than one year. Note that amount due to owner and/or related organizations should be separated.
EQUITY		
301.00	Capital	Owner's capital at balance sheet date.
310.00	Capital Stock	The par or stated value of stock owned at balance sheet date.
320.00	Paid in Capital	The amount of capital in excess of par or stated value of stock at balance sheet date.
392.00	Retained Earnings	Accumulated earnings after income taxes and after dividends have been paid to stockholders.
393.00	Net Profit or (Loss)	Net profit or (loss) from operation for current year to date before provisions for income taxes have been made.
PROPRIETOR DRAW		
395.00	Proprietor Draw	Amount withdrawn from the business by the owner(s) in cases where the facility is not a corporation.
ROUTINE REVENUE		The gross charges made to residents for room and board services, including general nursing, dietary, housekeeping and all other commonly used services and supplies available to all residents and normally expressed as a daily or monthly rate. In lieu of recording all charges and contractual adjustments, these accounts may be used to record

		amounts received (cash basis) during the period and applicable accrual adjustments at the beginning and end of the period.
402.00	Private, Other Third Party	Amounts billed to self-pay residents and other third parties for services/supplies, which are reimbursed on a per diem or monthly basis.
404.00	Medicare – Part A	Amounts billed to the Medicare Title XVIII Part A fiscal intermediary for SNF services/supplies, which are reimbursed on a per diem basis. This is the daily amount billed for room & board and does not include the Medicare Part A ancillary services/supplies which are billed separately.
405.00	Medicaid	Amounts billed to Medicaid for services/supplies, which are reimbursed on a per diem basis.
ANCILLARY REVENUE		In lieu of recording all changes and adjustments, these accounts may be used to record amounts received (cash basis) during the period and applicable accrual adjustments at the beginning and end of the period.
410.00	Medicare Part A Physical Therapy	Amounts billed to Medicare Part A for physical therapy services and supplies.
410.10	Medicare Part B Physical Therapy	Amounts billed to Medicare Part B for physical therapy services and supplies.
410.20	Other Physical Therapy	Amounts billed to other Third Parties and non-residents/employees/etc. for physical therapy services and supplies.
411.00	Medicare Part A Occupational Therapy	Amounts billed to Medicare Part A for occupational therapy services and supplies.
411.10	Medicare Part B Occupational Therapy	Amounts billed to Medicare Part B for occupational therapy services and supplies.
411.20	Other Occupational Therapy	Amounts billed to other Third Parties and non-residents/employees/etc. for occupational therapy services and supplies.
412.00	Medicare Part A Speech Therapy	Amounts billed to Medicare Part A for speech therapy services and supplies.
412.10	Medicare Part B Speech Therapy	Amounts billed to Medicare Part B for speech therapy services and supplies.
412.20	Other Speech Therapy	Amounts billed to other Third Parties and non-residents/employees/etc. for speech therapy services and supplies.
413.00	Medicare Part A Oxygen/Inhalation Therapy	Amounts billed to Medicare Part A for oxygen/inhalation therapy services and supplies.

413.10	Medicare Part B Oxygen/Inhalation Therapy	Amounts billed to Medicare Part B for oxygen/inhalation therapy services and supplies.
413.20	Other Oxygen/Inhalation Therapy	Amounts billed to other Third Parties and non-residents/employees/etc. for oxygen/inhalation therapy services and supplies.
414.00	Medicare Part A Intravenous Therapy	Amounts billed to Medicare Part A for intravenous therapy services and supplies.
414.10	Medicare Part B Intravenous Therapy	Amounts billed to Medicare Part B for intravenous therapy services and supplies.
414.20	Other Intravenous Therapy	Amounts billed to other Third Parties and non-residents/employees/etc. for intravenous therapy services and supplies.
415.00	Medicare Part A Pharmacy	Amounts billed to Medicare Part A for drugs and pharmaceuticals.
415.20	Other Pharmacy	Amounts billed to other Third Parties and non-residents/employees, etc. for drugs and pharmaceuticals.
416.00	Medicare Part A Nursing/Medical Supplies	Amounts billed to Medicare Part A for nursing and medical supplies.
416.10	Medicare Part B Nursing/Medical Supplies	Amounts billed to Medicare Part B for nursing and medical supplies.
416.20	Other Nursing/Medical Supplies	Amounts billed to other Third Parties and non-residents/employees/etc. for nursing and medical supplies.
417.00	Medicare Part A Laboratory	Amounts billed to Medicare Part A for laboratory services and supplies.
417.10	Medicare Part B Laboratory	Amounts billed to Medicare Part B for laboratory services and supplies.
417.20	Other Laboratory	Amounts billed to other Third Parties and non-residents/employees/etc. for laboratory services and supplies.
418.00	Part A X-Ray/Radiology	Amounts billed to Medicare Part A for X-Ray/Radiology services and supplies.
418.10	Part B X-Ray/Radiology	Amounts billed to Medicare Part B for X-Ray/Radiology services and supplies.
418.20	Other X-Ray/Radiology	Amounts billed to other Third Parties and non-residents/employees/etc. for X-Ray/Radiology services and supplies.
419.00	Part A Other Miscellaneous Ancillary	Amounts billed to Medicare Part A for miscellaneous ancillary services and supplies.
419.10	Part B Other Miscellaneous Ancillary	Amounts billed to Medicare Part B for miscellaneous ancillary services and supplies.
419.20	Other Miscellaneous Ancillary	Amounts billed to other Third Parties and non-residents/employees/etc. for miscellaneous ancillary services and supplies.

MISCELLANEOUS REVENUE

430.00	Television	Amounts received and receivable from television rental and cable fees from residents.
432.00	Beauty and Barber	Amounts received and receivable from the provision of beauty and barber services.
434.00	Personal Items	Amounts received and receivable from the sale of personal items such as toothpaste, razor blades, shaving cream, etc.
436.00	Vending	Amounts received and receivable from the sale of products in vending machines, such as candy bars and soda pop.
438.00	Rental	Amounts received and receivable from the rental of space or equipment.
440.00	Interest	Amounts received and receivable for interest earned on cash deposits or notes and accounts receivable.
442.00	Arts & Crafts	Amounts received and receivable from the sale of arts and craft items.
444.00	Meal	Amounts received and receivable from the sale of meals to guests and employees.
446.00	Laundry	Amounts received and receivable from the sale of laundry services.
448.00	Contributions, Gifts, Grants	Amounts received and receivable from contributions, gifts and grants.
449.00	Criminal Records Check	Amounts received and receivable for reimbursement of criminal records check disbursements.
450.00	Other	Amounts received and receivable for which a specific account is not established.
DEDUCTIONS		Contractual adjustments made to resident care revenue to reflect settlements for the difference between the billed amounts as recorded per general ledger revenue accounts and contracted amounts actually paid. These adjustments are usually made as a result of an agreement to accept payment amounts from a contracting third party agent which are less than the billed amounts.
501.00	Private Pay & Other Third Party Contractual Adjustment	Contractual adjustments made to Private Pay and Other Third Party covered charges.
503.00	Medicare Part A Contractual Adjustment	Contractual adjustments made to Medicare Part A covered charges.
504.00	Medicaid Contractual Adjustment	Contractual adjustments made to Medicaid covered

		charges.
505.00	Medicare Part B Contractual Adjustment	Contractual adjustments made to Medicare Part B covered charges.
ALLOWANCES		Year end adjustments to reduce billed amounts to estimated collectible amounts as recorded per general ledger revenue accounts.
522.00	Private Pay & Other Third Party Allowance	Allowance adjustment made to Private Pay and Other Third Party covered charges.
524.00	Medicare Part A Allowance	Allowance adjustment made to Medicare Part A covered charges.
525.00	Medicaid Allowance	Allowance adjustment made to Medicaid covered charges.
526.00	Medicare Part B Allowance	Allowance adjustment made to Medicare Part B covered charges.
DIRECT CARE EXPENSES		
601.00	Salaries – RNs	Salaries of Registered Nurses (excluding the DON).
602.00	Salaries – LPNs	Salaries of Licensed Practical Nurses.
603.00	Salaries – Aides	Salaries of Nurse Aides.
604.00	Salaries – Assistant Director of Nursing	Salaries of the Assistant Director of Nursing.
605.00	Salaries – Director of Nursing	Salaries of the Director of Nursing who is in a supervisory position.
606.00	Salaries – Occupational Therapists	Salaries of occupational therapists.
607.00	Salaries – Physical Therapists	Salaries of physical therapists.
608.00	Salaries – Speech Therapists	Salaries of speech therapists.
609.00	Salaries – Other Therapists	Salaries of therapists other than occupational, physical or speech therapists.
610.00	Salaries – Rehab Nurse Aide	Salaries of rehabilitation nurse aide. Each facility should have a nursing assistant who is designated to be the Rehabilitative nurse aide. This aide should be trained by the therapist to provide the maintenance program for those residents who require these services.
611.00	FICA – Direct Care	Cost of employer's portion of Social Security Tax for direct care staff.
612.00	Group Health - Direct Care	Cost of employer's contribution to employee Health Insurance for direct care staff.
613.00	Pensions – Direct Care	Cost of employer's contribution to employee pension plan for direct care staff.
614.00	Unemployment Taxes –Direct	Cost of employer's contribution to State and

	Care	Federal unemployment taxes for direct care staff.
615.00	Uniform Allowance - Direct Care	Cost of uniform allowance or uniforms given to staff as a fringe benefit for direct care staff.
616.00	Worker's Comp - Direct Care	Cost of worker's compensation insurance for direct care staff.
617.00	Other Fringe Benefits –Direct Care	Cost of other fringe benefits offered to direct care staff not specifically listed in the categories above. These must be included in the facility's benefits policy.
618.00	Contract – Aides	Cost of Certified Nurse Aides hired through contract that are not on the facility payroll.
619.00	Contract - LPN's	Cost of LPN's and graduate practical nurses hired through contract that are not on facility payroll.
620.00	Contract - RN's	Cost of RN's and graduate nurses hired through contract that are not on facility payroll.
621.00	Contract – Occupational Therapists	Cost of occupational therapists hired through contract that are not on the facility payroll.
622.00	Contract - Physical Therapists	Cost of physical therapists hired through contract that are not on facility payroll.
623.00	Contract - Speech Therapists	Cost of speech therapists hired through contract that are not on facility payroll.
624.00	Contract - Other Therapists	Cost of therapists other than occupational, physical, and speech therapists hired through contract that are not facility employees.
625.00	Consultant Fees – Nursing	Fees paid to nursing personnel, not on the facility payroll, for providing advisory and educational services to the facility.
626.00	Training – Direct Care	Cost of training related to resident care for RN's, LPN's and Certified Nurse Aides. Also includes travel costs associated with this training. Does not include training cost for Nurse Aide certification.
627.00	Over the Counter Drugs	Cost of over the counter drugs provided to its residents such as pain relievers, cough and cold medications, Rubbing Alcohol, aspirin.
628.00	Oxygen	Cost of oxygen and related supplies.
629.00	Medical Supplies - Direct Care	Cost of medical supplies such as catheters, syringes, sterile dressings, prep supplies, alcohol pads, Betadine solution in bulk, tongue depressors, cotton balls, thermometers and blood pressure cuffs.
630.00	Therapy Supplies	Cost of supplies used directly by the therapy staff for rendering therapeutic services to the residents of the facility.
631.00	Raw Food	Cost of food products used to provide meals and snacks to residents.

632.00	Food Supplements	Cost of food products given in addition to normal meals and snacks under doctor's orders (Ensure, etc.).
633.00	Incontinence Supplies	Cost of incontinence supplies to include diapers and underpads.
634.00	Dental	Cost of dental services.
635.00	Consultant Fees – Dental	Fees paid to a dentist, not on the facility payroll, for providing advisory and educational services to the facility.
636.00	Drugs – Legend	Cost of prescription drugs prescribed by the physician as medically necessary, provided by the facility to its residents.
637.00	Laboratory	Cost of laboratory procedures such as blood tests and urinalysis provided to it's on residents.
637.10	X-Ray	Cost of providing radiological services to its residents.

ADMINISTRATIVE AND OPERATING COSTS

701.00	Salaries – Administrator	Salaries of licensed administrators excluding owners.
702.00	Salaries - Assistant Administrator	Salaries of licensed assistant administrators excluding owners.
703.00	Salaries - Dietary Supervisor	Salaries of dietary supervisors.
703.10	Salaries - Dietary Staff	Salaries of kitchen personnel including cooks, helpers and dishwashers.
704.00	Salaries – Housekeeping Supervisor	Salaries of housekeeping supervisors.
704.10	Salaries - Housekeeping Staff	Salaries of housekeeping personnel including maids and janitors.
705.00	Salaries - Laundry Supervisor	Salaries of laundry supervisor.
705.10	Salaries - Laundry Staff	Salaries of laundry personnel except supervisors.
706.00	Salaries – Maintenance Supervisor	Salaries of the maintenance supervisors.
706.10	Salaries - Maintenance Staff	Salaries of personnel involved in operating and maintaining the physical plant, including maintenance men or plant engineer excluding the maintenance supervisor.
707.00	Salaries - Medical Records	Salaries of medical records personnel.
708.00	Salaries - Other Administrative	Salaries of other administrative personnel not included in other accounts.

708.10	Salaries – Bookkeeper	Salaries of personnel responsible for accumulating and maintaining financial and statistical records.
708.20	Salaries – Receptionist	Salaries of personnel answering telephones, greeting visitors, answering questions and performing secretarial functions.
709.00	Salaries – Activities	Salaries of Activities staff.
710.00	Salaries – Pharmacy	Salaries of pharmacy employees.
711.00	Salaries - Social Services	Salaries of personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental and psychosocial well being of the residents.
712.00	Salaries - Owner or Owner/Administrator	Salaries of all owners of the facility.
713.00	FICA – Indirect, Administrative & Operating	Cost of employer's portion of Social Security Tax for indirect, administrative & operating staff.
714.00	Group Health – Indirect, Administrative & Operating	Cost of employer's contribution to employee Health Insurance for indirect, administrative & operating staff.
715.00	Pensions – Indirect, Administrative & Operating	Cost of employer's contribution to employee pension plan for indirect, administrative & operating staff.
716.00	Unemployment Taxes – Indirect, Administrative & Operating	Cost of employer's contribution to State and Federal unemployment taxes for indirect, administrative & operating staff.
717.00	Uniform Allowance – Indirect, Administrative & Operating	Cost of uniform allowance or uniforms given to staff as a fringe benefit for indirect, administrative & operating staff.
718.00	Worker's Comp – Indirect, Administrative & Operating	Cost of worker's compensation insurance for indirect, administrative & operating staff.
719.00	Other Fringe Benefits – Indirect, Administrative & Operating	Cost of other fringe benefits offered to administrative staff not specifically listed in the categories above. These should be included in the facilities benefits policy.
720.00	Contract - Dietary	Cost of dietary services and personnel hired through contract that are not facility employees.
721.00	Contract - Housekeeping	Cost of housekeeping services and personnel hired through contract that are not facility employees.
722.00	Contract - Laundry	Cost of laundry services and personnel hired through contract that are not facility employees.
723.00	Contract - Maintenance	Cost of maintenance services and personnel hired through contract that are not facility employees, includes electricians, plumbers, locksmiths, etc.
724.00	Consultant Fees - Dietitian	Fees paid to consulting registered dietitians for advisory and educational services.
725.00	Consultant Fees - Medical	Fees paid to consulting medical records Accredited

	Records	Records Technicians or Medical Records Administrator for advisory and educational services.
726.00	Consultant Fees – Activities	Fees paid to activities personnel, not on the facility payroll, for providing advisory services to the facility.
727.00	Consultant Fees – Medical Director	Fees paid to a medical doctor, not on the facility payroll, for providing advisory and educational services to the facility.
728.00	Consultant Fees – Pharmacy	Fees paid to a registered pharmacist, not on the facility payroll, for providing advisory and educational services to the facility.
729.00	Consultant Fees - Social Worker	Fees paid to a social worker, not on the facility payroll, for providing advisory and educational services to the facility.
730.00	Consultant Fees – Therapists	Fees paid to licensed therapists, not on the facility payroll, for providing advisory and educational services to the facility.
731.00	Barber & Beauty Expense – Allowable	The cost of barber and beauty services provided to residents by facility staff.
732.00	Medical Transportation	Cost of providing residents medical transportation to local community providers when the facility does not use facility vehicles.
732.10	Business Related Mileage	Amounts claimed (rate per mile) for facility owned or other vehicles used in providing residents medical transportation to local "community" providers or used for business related mileage.
733.00	Resident Activities	Cost of resident activities should include pastoral services, recreational activities and supplies (games, puzzles, art supplies).
733.10	Supplies - Care Related	Cost of supplies used by the care related staff for rendering care related services to residents of the facility including personal hygiene items such as shampoo and soap, nursing charting forms, admission forms, medication and treatment records, physician order forms.
735.00	Accounting Fees	Fees paid for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services, excluding personal tax planning and personal tax return preparation.
735.10	Payroll Processing	Fees paid to banks, data processing companies, or accounting firms for preparing the facility payroll.
736.00	Advertising for Labor/Supplies	Advertising expense limited to classified advertisements for the purpose of procurement of resident care related labor or supplies.

		Advertisements, including yellow page listings, designed to promote the facility or to solicit residents are not allowable.
737.00	Amortization Exp. - Non-Capital	Costs incurred for legal and other expenses when organizing a corporation should be amortized over a period of 60 months.
738.00	Bank Service Charges	Fees paid to banks for service charges, excluding penalties and insufficient funds charges.
739.00	Criminal Records Check	Costs incurred for criminal records checks for employee and job applicants.
740.00	Data Processing Fees	Cost of purchased services for data processing systems and services.
741.00	Dietary Supplies	Cost of consumable items such as soap, detergent, napkins, paper cups, straws, etc. used in the dietary department.
741.10	Dietary Non-Expendable Supplies	Cost of non-expendable dietary supplies such as forks, spoons, trays, plates, cups, bowls, glasses, etc.
742.00	Dues	Cost of dues paid for membership in industry associations.
743.00	Educational Seminars & Training	The cost of registration for attending educational seminars and training by employees of the facility and costs incurred in the provision of in-house training for facility staff. Do not include travel.
744.00	Governing Body	Cost of Governing Body.
745.00	Housekeeping Supplies	Cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.
746.00	Interest Expense - Non-Capital	Interest paid on short term borrowing for facility operations.
747.00	Laundry Supplies	Cost of consumable goods used in the laundry including soap, detergent, starch and bleach.
748.00	Legal Fees	Fees paid to attorneys.
749.00	Linen & Laundry	Cost of sheets, blankets, pillows and gowns.
750.00	Miscellaneous	Cost incurred in providing nursing facility services that cannot be assigned to any other account.
750.10	License Fees	Fees for licenses including state, county and local business licenses as well as nursing facility and administrator licensing fees.
750.20	Printing	Cost of printing forms and stationary including accounting and census forms, charge tickets, facility letterhead, etc.
752.00	Management Fees & Home Office	The cost of purchased management services or home office costs incurred that are allowable to the provider.

753.00	Office Supplies	Cost of consumable items used in the business office (pencils, erasers, paper, staples, computer paper, ribbons).
753.10	Subscriptions	Cost of subscribing to newspapers, magazines and periodicals for facility use.
754.00	Postage	Cost of postage including stamps, metered postage, freight charges and courier services.
755.00	Repairs & Maintenance	Cost of supplies and services used to repair the facility building, furniture and equipment (include light bulbs, nails, lumber, glass).
755.10	Vehicle Maintenance	Costs of maintaining facility vehicles including gas, oil, tires and auto insurance.
755.20	Painting	Supplies and services.
755.30	Gardening	Supplies and services for lawn care.
756.00	Taxes, Other	The cost of taxes paid that are not included in any other account.
757.00	Telephone & Communications	Cost the telephone services, WATTS lines and FAX services.
758.00	Travel	Cost of travel (airfare, mileage, lodging, meals, etc.) by Administrator and other authorized personnel to attend professional and continuing educational seminars and meetings related to their position within the facility.
759.00	Utilities	Cost of utility services not specified in other accounts such as cable TV for common areas. .
759.10	Utilities - Heating	Cost of gas, or other heating fuel services.
759.20	Utilities - Electricity	Cost of electric services.
759.30	Utilities - Water, Sewer & Garbage	Cost of water, sewer and garbage collection.
760.00	Depreciation - Vehicles	Depreciation on vehicles.
761.00	Interest - Vehicles	Interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase facility vehicles.

PROPERTY

801.00	Amortization Expense - Capital	Legal and other costs incurred when financing the facility which are amortized over the life of the mortgage.
802.10	Depreciation - Land Improvements	Depreciation on improvements having a limited life made to the land of the facility (paving, landscaping).
802.20	Depreciation - Building	Depreciation on the facility's building and attached assets.
802.30	Depreciation - Building	Depreciation on major additions or improvements

	Improvements	to the facility. For example a new laundry or dining room.
802.40	Depreciation - Equipment	Depreciation on items of movable equipment costing $300 or more such as beds, floor polishers, stoves, washing machines, computers, etc..
802.45	Depreciation – Software	Depreciation on software.
802.50	Depreciation - Leasehold Improvements	Depreciation on major additions or improvements to building or plant where the facility is leased and the cost of the changes are incurred by the lessee.
802.60	Depreciation - Generator	Depreciation on generators approved by the Office of Long Term Care under Act 1602 of 2001.
803.10	Interest - Land/Building	Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facilities real property (land and building).
803.20	Interest -Furniture/Equipment	Interest paid or accrued on notes, mortgages, and other loans, the proceeds of which were used to purchase the facility's furniture and equipment.
803.30	Interest - Generator	Interest paid or accrued on notes the proceeds of which were used to purchase generators approved by the Office of Long Term Care under Act 1602 of 2001.
804.00	Property Insurance	Cost of fire and casualty insurance on facility buildings and equipment.
805.00	Insurance - Professional Liability	Cost of insuring the facility against injury and malpractice claims.
806.00	Property Taxes	Cost of taxes levied on the facility's land and buildings.
807.00	Rent - Building	Cost of leasing the facility's real property (land and building).
808.00	Rent - Furniture & Equipment	Cost of leased or rented furniture and equipment for the facility.

QUALITY ASSURANCE FEE

820.00	Quality Assurance Fee	Cost of the quality assurance fee paid monthly to the Department of Human Services.

NON-ALLOWABLE COSTS

831.00	Advertising	Cost of advertisements in magazines, newspapers, trade publications, radio, TV and yellow pages which seeks to increase resident utilization of the nursing facility.
832.00	Bad Debts	Accounts receivable written off as uncollectable.
833.00	Barber & Beauty	Cost directly related to the provision of beauty and barber services to residents. The cost of beauty

		and barber services provided by facility staff are considered allowable costs and should be recorded in account 731.00.
834.00	Contributions	Amounts donated to charitable, political or other organizations.
836.00	Income Taxes - State & Federal	Taxes on net income levied or expected to be levied by the federal or state government.
837.00	Insurance - Officers	Cost of life insurance on officers and/or key employees of the facility.
839.00	Non-Working Officer's Salaries	Salaries and other compensation paid to non-working officers.
840.00	Nurse Aide Testing	Costs incurred in having nurse aides tested in order to meet OBRA 1987 provisions that have been or will be submitted to the Division of Medical Services for direct reimbursement. This includes both the Medicaid and non-Medicaid portion of the expenses.
841.00	Nurse Aide Training	Costs incurred in having nurse aide training in order to meet OBRA 1987 provisions that have been or will be submitted to the Division of Medical Services for direct reimbursement. This includes both the Medicaid and non-Medicaid portion of the expenses.
842.00	Other Non-Allowable Cost	Other costs that are considered non-allowable in accordance with other provisions of the state plan that does not have a specific account established.
842.10	Gift Shop	Cost of products sold in the gift shop and other costs that are directly associated with the sale of those products.
843.00	Penalties & Sanctions	Penalties and sanctions assessed by the Division of Medical Services, the Internal Revenue Service or the State Tax Commission, insufficient funds charges, etc..
844.00	Television	Cost of television sets used in the residents' rooms or for providing cable TV to the residents' rooms..
845.00	Vending Machines	Cost of items sold to employees, residents and the general public including candy bars and soft drinks.
846.00	Goodwill Amortization	Amortization of amount paid for a facility in excess of the book value of its tangible assets.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
GENERAL INFORMATION

I. PROVIDER FACILITY

Facility Name		Provider Number
D/B/A (If Applicable)		Vendor Number
Address		County
		County Number
Administrator	AR License Number	Phone
Contact Person	Title	Phone
Report Period: From	To	Number of Months
Financial Records For Audit Are Located At:		
All Correspondence and Desk Reviews Regarding This Cost Report Should Be Addressed To (Limited to one name and address):		

II. HOME OFFICE (IF APPLICABLE)

Name of Home Office	
Address	
Contact Person	Phone
Names of Other Nursing Home Facilities In Arkansas Owned By The Above:	

III. MANAGEMENT COMPANY (IF APPLICABLE) ( ) Related Party ( ) Non-Related

Name of Management Company	
Address	
Contact Person	Phone

IV. FOR DIVISION OF MEDICAL SERVICES USE ONLY

Date Cost Report Mailed _____ Date Cost Report Received _____

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

Facility Name Vendor Number

Address

The enclosed cost report is submitted for the cost reporting period beginning _____
and ending _____

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

This Cost Report is submitted as a part of the request by this Long-Term Care Provider for reimbursement under the Arkansas Medicaid Program.

I HEREBY CERTIFY that I have examined the contents of the accompanying cost report to the State of Arkansas, Department of Human Services, Division of Medical Services for the period stated above and certify to the best of my knowledge and belief that the said contents are true and correct statements prepared from the books and records of this facility in accordance with applicable instructions.

(Signed) _____
Officer or Administrator of Provider

_____
Title

_____
Date

Cost Report Prepared By:

Name _____

Address _____

_____

_____

Name of Contact Person _____

Telephone Number _____

NOTE: Attach Accountants' report, if applicable.

DOM400-3

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
STATISTICAL DATA

Facility Name

Vendor Number Period: From To

1. Type of Control:
   Nonprofit: ( ) Church ( ) Other
   Proprietary: ( ) Individual ( ) Partnership
   ( ) Corporation ( ) Limited Liability Company
   Government Operated: ( ) State ( ) County ( ) City

2. A) Facility: ( ) Owned ( ) Leased ( ) Leased from Related Party
   B) Facility has common ownership with other nursing facilities located in Arkansas: ( ) Yes ( ) No
   C) Facility has common ownership with other nursing facilities located outside of Arkansas: ( ) Yes ( ) No
   D) Hospital Based: ( ) Yes ( ) No

3. Accounting Basis: ( ) Accrual ( ) Cash

4. RESIDENT DAYS	**Column A**	**Column B**	**Column C**	**Column D**	**Column E**
	Total	Medicaid	Medicare	Private	Other
4.1 By Payment Source:					
	Total	Skilled	Int. I	Int. II	Int. III
4.2 Total Days by Level of Care					
4.3 Medicaid Days by Level of Care					

5. Licensed Beds at Beginning of Period	
6. Licensed Beds at End of Period	
7. Date of Change in Number of Beds, if Applicable	
8. Bed Days Available for Period	
9. Percentage of Occupancy (Line 4.1, Column A / Line 8)	
10. Percentage of Medicaid Utilization (Line 4.1, Column B / Line 4.1, Column A)	

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
RESIDENT DAY STATISTICS

Facility Name

Vendor Number Period: From To

I. Monthly Resident Days

Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7	Column 8
MONTH	MEDICAID DAYS	MEDICARE DAYS	PRIVATE DAYS	OTHER DAYS	TOTAL RESIDENT DAYS	BED DAYS AVAILABLE	PERCENTAGE OF OCCUPANCY
July							
August							
September							
October							
November							
December							
January							
February							
March							
April							
May							
June							
TOTALS							

NOTE: Hold and Leave Days are to be included in the Monthly Resident Days listed above. The totals should agree with the reported days on Form 3, Lines 4.1, 4.2 and 4.3.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
RESIDENT DAY STATISTICS

Facility Name

Vendor Number Period: From To

II. Third Party Pay Rates

List the facility's third party pay rates during the reporting period. If a change of rates occurred during the period, list each rate structure and the dates the rates were in effect.

Dates Effective				Rates				Resident Days			
From	To	Payor Source	Room Type	Skilled	Int I	Int II	Int III	Skilled	Int I	Int II	Int III
		Medicare									
			Private								
		Private Pay									
			Private								
			Semi Private								
			Other								
			Private								
			Semi Private								
			Other								
			Private								
			Semi Private								
			Other								
		Other									
			Private								
			Semi Private								
			Other								
			Private								
			Semi Private								
			Other								
			Private								
			Semi Private								
			Other								

Total Medicaid Days by Level of Care (Form 3, Line 4.3)				
Total Days by Level of Care (Should = Form 3, Line 4.2)				

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
STATEMENT OF REVENUES

Facility Name			
Vendor Number Period: From		To	
DESCRIPTION	**Column 1 PER GENERAL LEDGER**	**Column 2 ADJUSTMENT TO FORM 6 COLUMN 5**	**Column 3 FORM 6 LINE # ADJUSTED**
1. Resident Per Diem/Monthly Rate			
2. Medicare Part A Ancillaries		NA	NA
3. Medicare Part B Ancillaries		NA	NA
4. Other Third Party Ancillaries (Schedule)		NA	NA
5. Less: Total Contractual Adjustments, Allowances & Discounts on Patients' Accounts	( )		
6. Pharmacy			
7. Beauty and Barber			
8. Contributions, Gifts, Grants, etc.			
9. Guest and Employee Meals			
10. Interest			
11. Laundry			
12. Personal Items			
13. Nurse Aide Training and Testing		NA	NA
14. Rental			
15. Television (Resident Rooms)		NA	NA
16. Telephone			
17. Vending Machines		NA	NA
18. Criminal Records Check			
19. Other (Schedule)			
20. Total Revenue			
21. Less: Total Operating Expenses			
22. Net Income (Loss) Per Books			
23. Less: Net Related Party Adjustments			
24. Other Adjustments (Schedule)			
25. Adjusted Net Income (Loss)			

NA - Not Applicable. Expense is not allowable.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Allowable Expense
1	**DIRECT CARE**						
1-01	Salaries - Aides						
1-02	Salaries - LPN's						
1-03	Salaries - RN's (exclude DON & Asst. DON)						
1-04	Salaries - Assistant Director of Nursing						
1-05	Salaries - Director of Nursing						
1-06	Salaries - Occupational Therapists						
1-07	Salaries - Physical Therapists						
1-08	Salaries - Speech Therapists						
1-09	Salaries - Other Therapists						
1-10	Salaries - Rehabilitation Nurse Aides						
1-11	FICA - Direct Care						
1-12	Group Health - Direct Care						
1-13	Pensions - Direct Care						
1-14	Unemployment Taxes - Direct Care						
1-15	Uniform Allowance - Direct Care						
1-16	Worker's Compensation - Direct Care						
1-17	Other Fringe Benefits - Direct Care (Schedule)						
1-18	Contract - Aides						
1-19	Contract - LPN's						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number | Period: From | To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Allowable Expense
1	**DIRECT CARE**						
1-20	Contract - RN's						
1-21	Contract - Occupational Therapists						
1-22	Contract - Physical Therapists						
1-23	Contract - Speech Therapists						
1-24	Contract - Other Therapists						
1-25	Consultant Fees - Nursing						
1-26	Training - Direct Care (Schedule)						
1-27	Over-the-Counter Drugs						
1-28	Oxygen						
1-29	Medical Supplies - Direct Care						
1-30	Therapy Supplies						
1-31	Raw Food						
1-32	Food Supplements						
1-33	Incontinence Supplies						
1-34	Dental (Schedule)						
1-35	Drugs Legend						
1-36	Lab and X-Ray						
1-37	**Total Direct Care Expenses**						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Allowable Expense
2	**INDIRECT, ADMINISTRATIVE & OPERATING**						
2-01	Salaries - Administrator						
2-02	Salaries - Assistant Administrator						
2-03	Salaries - Dietary						
2-04	Salaries - Housekeeping						
2-05	Salaries - Laundry						
2-06	Salaries - Maintenance						
2-07	Salaries - Medical Records						
2-08	Salaries - Other Administrative						
2-09	Salaries - Activities						
2-10	Salaries - Pharmacy						
2-11	Salaries - Social Services						
2-12	Salaries - Owner or Owner/Administrator						
2-13	FICA - Indirect, Admin. & Operating						
2-14	Group Health - Indirect, Admin. & Operating						
2-15	Pensions - Indirect, Admin. & Operating						
2-16	Unemployment Taxes - Indirect, Admin. & Oper.						
2-17	Uniform Allowance - Indirect, Admin. & Operating						
2-18	Worker's Comp - Indirect, Admin. & Operating						
2-19	Other Fringe Benefits - Ind., Adm. & Oper. (Sch)						
2-20	Contract - Dietary						
2-21	Contract - Housekeeping						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Allowable Expense
2	**INDIRECT, ADMINISTRATIVE & OPERATING**						
2-22	Contract - Laundry						
2-23	Contract - Maintenance						
2-24	Consultant Fees - Dietician						
2-25	Consultant Fees - Medical Records						
2-26	Consultant Fees - Activities						
2-27	Consultant Fees - Medical Director						
2-28	Consultant Fees - Pharmacy						
2-29	Consultant Fees - Social Worker						
2-30	Consultant Fees - Therapists						
2-31	Barber & Beauty Expense - Allowable						
2-32	Transportation						
2-33	Resident Activities						
2-34	Care Related Supplies						
2-35	Accounting Fees						
2-36	Advertising for Labor/Supplies						
2-37	Amortization Expense - Non-Capital (Schedule)						
2-38	Bank Service Charges						
2-39	Criminal Records Checks						
2-40	Data Processing Fees						
2-41	Dietary Supplies						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Allowable Expense
2	**INDIRECT, ADMINISTRATIVE & OPERATING**						
2-42	Dues (Schedule)						
2-43	Educational Seminars & Training						
2-44	Governing Body (Schedule)						
2-45	Housekeeping Supplies						
2-46	Laundry Supplies						
2-47	Legal Fees (Schedule)						
2-48	Linen & Laundry Alternatives						
2-49	Miscellaneous (Schedule)						
2-50	Management Fees & Home Office Costs						
2-51	Office Supplies & Subscriptions						
2-52	Postage						
2-53	Repairs & Maintenance						
2-54	Taxes - Other (Schedule)						
2-55	Telephone & Communications						
2-56	Travel (Schedule)						
2-57	Utilities						
2-58	Depreciation - Vehicles & Software						
2-59	Interest - Working Capital, Vehicles & Software						
2-60	**Total Indirect, Administrative & Operating**						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Reported Expense
3	**PROPERTY**						
3-01	Amortization Expense - Capital (Schedule)						
3-02	Depreciation - Fair Market Rental						
3-03	Depreciation - Generator						
3-04	Interest Expense - Fair Market Rental						
3-05	Interest Expense - Generator						
3-06	Property Insurance						
3-07	Professional Liability Insurance						
3-08	Property Taxes						
3-09	Rent - Building						
3-10	Rent - Furniture & Equipment						
3-11	**Total Property**						
4	**Quality Assurance Fee**						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name

Vendor Number Period: From To

Line No.	Account	Column 1 Expense Per Books	Column 2 Reclassification	Column 3 Related Party Exp. Adjustment	Column 4 Total Expense	Column 5 Adjustments	Column 6 Reported Expense
5	**NON-ALLOWABLE COSTS**						
5-01	Advertising					( )	0
5-02	Bad Debts					( )	0
5-03	Barber and Beauty Expense					( )	0
5-04	Contributions					( )	0
5-05	Depreciation Over Straight Line					( )	0
5-06	Income Taxes - State & Federal					( )	0
5-07	Insurance - Officers					( )	0
5-08	Non-Working Officer's Salaries					( )	0
5-09	Nurse Aide Testing					( )	0
5-10	Nurse Aide Training					( )	0
5-11	Other Non-Allowable Costs					( )	0
5-12	Penalties & Sanctions					( )	0
5-13	Television & Cable (Resident Rooms)					( )	0
5-14	Vending Machines					( )	0
5-15	Goodwill					( )	0
5-16	**Total Non-Allowable Costs**					( )	0
6	**TOTAL COSTS**		**0**			( )	

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF EXPENSES

Facility Name			
Vendor Number	Period: From	To	
Line No.	**Account**		
7	Total Resident Days (From Form 3, Line 4.1, Column A)		
		Column A Computation of Cost	**Column B Cost Per Day**
8	Direct Care Costs (Column A should equal Line 1-37. Column B = Line 8, Column A / Line 7)		
9	Indirect, Administrative and Operating Costs (Column A should agree with Line 2-60. Column B = Line 9, Column A / Line 7)		
10	Property Costs (Column A should equal Line 3-11. Column B = Line 10, Column A / Line 7)		
11	Quality Assurance Fee (Column A should agree with Line 4. Column B = Line 11, Column A / Line 7)		
12	Total Costs (Total of Column A should agree with Line 6. Column B = Line 12, Column A / Line 7)		

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF FIXED ASSETS AND DEPRECIATION - FACILITY OWNED ASSETS

Facility Name

Vendor Number Period: From To

Description of Property	Column 1 Historical Cost	Column 2 Ending Accumulated Depreciation	Column 3 Depreciation Expense	Column 4 Other Adjustments (Schedule)	Column 5 Nursing Facility Related Depreciation
Land					
Buildings and Improvements					
Leasehold Improvements					
Furniture and Movable Equipment					
Vehicles					
Generator					
Software					
Other (Specify)					
Totals					

Specify any assets included above that are not related to resident care (unallowable vehicles, allocated unallowable vehicles per usage, mobile homes, boats, RV's, etc.) Adjustments for these assets will be made in in Column 4 above. Please attach copies of workpapers/schedules identifying how the adjustments were calculated.

PLEASE NOTE: A copy of the facility's depreciation schedule (straight-line method) must be attached to the cost report. The depreciation schedule must balance with the schedule above and must show asset description, date of acquisition, historical cost, salvage value if used, depreciable base, accumulated depreciation to date, useful life and depreciation claimed this period for each item. Straight line depreciation is the only allowable method for reporting purposes.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF FIXED ASSETS AND DEPRECIATION - RELATED PARTY OWNED ASSETS

Facility Name

Vendor Number Period: From To

Description of Property	Column 1 Historical Cost	Column 2 Ending Accumulated Depreciation	Column 3 Depreciation Expense	Column 4 Other Adjustments (Schedule)	Column 5 Nursing Facility Related Depreciation
Land					
Buildings and Improvements					
Leasehold Improvements					
Furniture and Movable Equipment					
Vehicles					
Generator					
Software					
Other (Specify)					
Totals					

Specify any assets included above that are not related to resident care (unallowable vehicles, allocated unallowable vehicles per usage, mobile homes, boats, RV's, etc.) Adjustments for these assets will be made in in Column 4 above. Please attach copies of workpapers/schedules identifying how the adjustments were calculated.

PLEASE NOTE: A copy of the related party asset depreciation schedule (straight-line method) must be attached to the cost report. The depreciation schedule must balance with the schedule above and must show asset description, date of acquisition, historical cost, salvage value if used, depreciable base, accumulated depreciation to date, useful life and depreciation claimed this period for each item. Straight line depreciation is the only allowable method for reporting purposes.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
SCHEDULE OF FIXED ASSETS AND DEPRECIATION - TOTAL ASSETS

Facility Name

Vendor Number Period: From To

Description of Property	Column 1 Historical Cost	Column 2 Ending Accumulated Depreciation	Column 3 Depreciation Expense	Column 4 Other Adjustments (Schedule)	Column 5 Nursing Facility Related Depreciation
Land					
Buildings and Improvements					
Leasehold Improvements					
Furniture and Movable Equipment					
Vehicles					
Generator					
Software					
Other (Specify)					
Totals					

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS

FACILITY TRANSACTIONS WITH RELATED ORGANIZATIONS

Facility Name

Vendor Number Period: From To

I. Are any costs included in the allowable costs on Form 6 which are a result of transactions with a related organization as defined in the Long Term Care Manual of Cost Reimbursement Rules?

YES _____ NO _____
(If yes, compete Section II. and III. below)

II. Costs incurred as a result of transactions with related organizations:

Form Number	Line Number	Name of Related Organization	Transaction Amount	Cost to Related Organization	Amount in Excess of Cost*

*Adjustments to expenses should be made to the appropriate line on Form 6, Column 3 for all related party expense adjustments. For related party lease agreements, unallowable lease costs should be removed in total on Lines 3-09 and 3-10 and the actual cost of amortization, depreciation, interest, property insurance and property taxes should be posted to Lines 3-01, 3-02, 3-03, 3-04, 3-05, 3-06 and 3-08, Column 3 respectively. See also instructions for reporting related party depreciation and related party interest per Form 7 and Form 10.

III. Name and percentage of ownership in the related organization:

Name of Owner	Name of Related Organization	Percent of Ownership

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
RENTAL OF PROPERTY, PLANT AND EQUIPMENT

Facility Name

Vendor Number Period: From To

I. RENTAL PAYMENTS INCLUDED ON FORM 6, LINE 5-09, RENT-BUILDING, COLUMN 1

Lessor	Description of Property Leased	Description of Lease Terms	Description of Purchase Option, If Any	Current Period Expense
Total to Form 6, Line 5-09, Column 1				

II. RENTAL PAYMENTS INCLUDED ON FORM 6, LINE 5-10, RENT-FURNITURE & EQUIPMENT, COLUMN 1

Lessor	Description of Property Leased	Description of Lease Terms	Description of Purchase Option, If Any	Current Period Expense
Total to Form 6, Line 5-10, Column 1				

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
ANALYSIS OF INTEREST BEARING DEBT AND RELATED INTEREST EXPENSE
LOAN AGREEMENTS PER FACILITY BOOKS

Facility Name				
Vendor Number	Period: From		To	
	Note 1 (Col.1)	**Note 2 (Col. 2)**	**Note 3 (Col. 3)**	**Note 4 (Col. 4)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				
	Note 5 (Col. 5)	**Note 6 (Col. 6)**	**Note 7 (Col. 7)**	**Note 8 (Col. 8)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				
	Note 9 (Col. 9)	**Note 10 (Col. 10)**	**Note 11 (Col. 11)**	**TOTAL (Col. 12)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
ANALYSIS OF INTEREST BEARING DEBT AND RELATED INTEREST EXPENSE
LOAN AGREEMENTS PER RELATED PARTY BOOKS

Facility Name				
Vendor Number	Period: From		To	
	Note 1 (Col.1)	**Note 2 (Col. 2)**	**Note 3 (Col. 3)**	**Note 4 (Col. 4)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				
	Note 5 (Col. 5)	**Note 6 (Col. 6)**	**Note 7 (Col. 7)**	**Note 8 (Col. 8)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				
	Note 9 (Col. 9)	**Note 10 (Col. 10)**	**Note 11 (Col. 11)**	**TOTAL (Col. 12)**
1. Lender				
2. Original Loan Amount				
3. Beginning Balance				
4. Ending Balance				
5. Current Portion				
6. Long-Term Portion				
7. Terms of Debt				
8. Asset Financed				
9. Interest Rate				
10. Allowable Int. - Fair Market Rental				
11. Allowable Interest - Generator				
12. Allowable Int. - W. Capital & Other				
13. Non-Allowable Interest				

DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
ANALYSIS OF INTEREST BEARING DEBT AND RELATED INTEREST EXPENSE
FOR TOTAL LOAN AGREEMENTS

Facility Name		
Vendor Number	Period: From	To
		Total
		All Notes
1. Lender		
2. Original Loan Amount		
3. Beginning Balance		
4. Ending Balance		
5. Current Portion		
6. Long-Term Portion		
7. Terms of Debt		
8. Asset Financed		
9. Interest Rate		
10. Allowable Int. - Fair Market Rental		
11. Allowable Interest - Generator		
12. Allowable Int. - W. Capital & Other		
13. Non-Allowable Interest		

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
BALANCE SHEET

Facility Name		
Vendor Number Period: From To		
Account Description	**Column 1 Beginning of Reporting Period**	**Column 2 End of Reporting Period**
ASSETS		
Current Assets:		
1. Cash on Hand & in Banks		
2. Accounts Receivable		
3. Less Allowance for Uncollectible Accounts		
4. Notes Receivable		
5. Due From Officers, Owners or Related Organizations		
6. Other Receivables		
7. Inter-Company Receivables		
8 . Inventory		
9. Prepaid Expenses		
10. Investments		
11. Other Current Assets:		
12. Total Current Assets		
Fixed Assets:		
13. Property, Plant and Equipment (Form 7, Page 1)		
14. Less Accumulated Depreciation (Form 7, Page 1)		
15. Total Fixed Assets		
Other Assets:		
16. Notes Receivable-Noncurrent		
17. Due From Officers, Owners or Related Organizations		
18. Deposits (Schedule)		
19. Other Noncurrent Assets:		
20. Total Other Assets		
21. TOTAL ASSETS		

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
BALANCE SHEET

Facility Name		
Vendor Number Period: From To		
Account Description	**Column 1 Beginning of Reporting Period**	**Column 2 End of Reporting Period**
Current Liabilities:		
22. Accounts Payable		
23. Notes Payable and Current Portion of Long Term Debt		
24. Accrued Salaries		
25. Accrued Payroll Taxes		
26. Accrued Income Taxes		
27. Inter-Company Payables		
28. Other Current Liabilities:		
29. Total Current Liabilities		
Long-Term Liabilities		
30. Mortgage Payable		
31. Notes Payable		
32. Notes Payable to Officers, Owners or Related Organizations		
33. Total Long-Term Liabilities		
34. TOTAL LIABILITIES		
Capital:		
35. Individual		
36. Partnership - Partners' Capital Accounts		
37. State, County or Other Fund Balance		
38. Capital Stock		
39. Additional Paid-in-Capital		
40. Retained Earnings		
41. Treasury Stock		
42. TOTAL CAPITAL		
43. TOTAL LIABILITIES AND CAPITAL		

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS

CAPITAL RECONCILIATION

Facility Name		
Vendor Number Period: From		To
Total Capital at Beginning of Period (Form 11, Line 42, Column 1)		
Additions to Capital		
1. Net Income (Loss) for Period (Form 5,Line 22)		
2. Contributions to Capital:		
Date:		
3.		
4.		
Total Additions to Capital		
Subtotal		
Reductions to Capital		
1. Dividends Paid		
2. Owners' or Partners' Withdrawals:		
Date:		
3.		
4.		
Total Reductions to Capital		
Total Capital at End of Reporting Period (Form 11, Line 42, Column 2)		

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS

OWNERS' COMPENSATION

Facility Name

Vendor Number Period: From To

NOTE: A FORM 13 MUST BE INCLUDED FOR EACH OWNER/PARTNER/STOCKHOLDER IDENTIFIED ON FORM 14

Name of Owner/Partner/Stockholder

I. Compensation Paid	**Form 6 Line Number**	**Form 6, Column 6 Amount**
Facility-		
Salary		
Health Insurance		
Life Insurance		
*Other Compensation:		
Related Management Company/Home Office-		
Salary, Health Ins., Life Ins., Other Comp.	2-51	
Total Allowable Compensation - This Facility		

*Includes but is not limited to the following:

1. Supplies and services for personal use of the owner.
2. Merchandise ordered from wholesalers for the owner's personal use.
3. Personal use of a car, truck or other equipment owned by the facility.
4. Personal insurance premium paid for the owner.
5. Consultant fees.
6. Director's fees.

If the facility is a corporation, was the entire compensation paid within the cost reporting period or within 75 days of the close of the period?

YES _____ NO _____

II. Resident care function for which compensation is claimed: (Check One)

_____ Administrator
_____ Assistant Administrator
_____ Other (identify and give brief work description)

III. Specific Duties of Function checked above:

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
OWNERS' COMPENSATION

Facility Name

Vendor Number Period: From To

Name of Owner/Partner/Stockholder

IV. DIRECT RESPONSIBILITY OF OWNER/PARTNER/STOCKHOLDER for other functions:
(Check where applicable)

_____ Accounting
_____ Purchasing
_____ Personnel
_____ Public Relations (Unallowable)
_____ Other (Please Identify)

V. Percentage of Ownership in this facility. _____

VI. Do you have any interest in any other facilities in Arkansas or other states?

YES _____ NO _____

If yes, please complete the following:

Name of Facility	Address	Percentage of Ownership

Do you have any interest in any business providing goods or services to this facility or any other facility listed above?

YES _____ NO _____

If yes, complete the related organizations section on Form 8.

VII. Analysis of Compensation Paid to Relatives of Owner/Partner/Stockholder:

Persons Related to Owner, Partner or Stockholder - Compensation paid to an employee who is an immediate relative of an owner, partner or stockholder of the facility is also reviewable under the test of reasonableness. For this purpose, the following persons are considered immediate relatives: (1) husband and wife; (2) natural parent, child and sibling; (3) adopted child and adoptive parent; (4)stepparent, stepchild, stepbrother and stepsister; (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law and sister-in-law; (6) grandparent and grandchild.

Name	Relationship	Position	Form 6, Line Number	Total Amount Paid	Average Hours Worked Per Week

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
OWNERS' COMPENSATION

Facility Name		
Vendor Number	Period: From	To
Name of Owner/Partner/Stockholder		
VIII.	**Indicate the estimated AVERAGE number of hours worked by the owner/ Partner/Stockholder each week in resident care activities in this facility.**	
	Estimated average hours spent each week in nonfacility activity:	
	Occupation:	
	Occupation:	
	Occupation:	
	Estimated average hours spent each week in other facilities:	
	Related Management Company/Home Office (No Specific Facility):	
	Facility Name:	
	Facility Name:	
	Facility Name:	
	Facility Name:	
	Facility Name:	
	Facility Name:	
	Facility Name:	
	Total estimated AVERAGE number of hours worked each week.	

I HEREBY CERTIFY that I have examined the above and certify to the best of my knowledge and belief that the said contents of this Form 13 are true and correct statements.

_____
Signature of Owner/Partner/Stockholder

_____
Date

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS

DISCLOSURE OF OWNERSHIP

Facility Name					
Vendor Number	Period: From		To		
Name of Owner, Partners, Major Stockholders, and Officers	**Title**	**Address**	**Percentage Owned**	**Direct Compensation from Facility**	**Form 15 Compensation Amount**
1. Sole Proprietor					
2. Partnership					
3. Corporation*					
Name of Corporation:					
4. Governmental - Name of Governmental Entity					

*List all stockholders having a 5% or more ownership of outstanding capital stock, all corporate officers of the corporation and all members of the Board of Directors.

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
HOME OFFICE OR RELATED MANAGEMENT COMPANY COST REPORT EXPENSE ALLOCATION SUMMARY

Facility Name: Vendor Number:

Home Office /Related Management Co.: Period: From To

Line No.	Account	Column 1 Per General Ledger	Column 2 Adjustments	Column 3 Directly Related Expenses This Facility	Column 4 Directly Related Expenses Other Facilities	Column 5 Expenses to be Allocated	Column 6 Allocated Expenses
1	**REVENUE**						
1-01	Management (Owned)						
1-02	Management (Non-Owned)						
1-03	Accounting						
1-04	Consulting						
1-05	Rental and Leasing						
1-06	Sale of Supplies						
1-07	Interest Income						
1-08	Other (Attach Schedule)						
1-09	**TOTAL REVENUE**						
2	**EXPENDITURES**						
2-01	Salaries-Owners and Officers						
2-02	Salaries-Other						
2-03	FICA						
2-04	Group Health						
2-05	Pensions						
2-06	Unemployment Taxes						
2-07	Workmen's Comp						
2-08	Accounting						
2-09	Advertising						
2-10	Amortization						
2-11	Consultants						
2-12	Contracted Services						
2-13	Depreciation						
2-14	Director Fees						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
HOME OFFICE OR RELATED MANAGEMENT COMPANY COST REPORT EXPENSE ALLOCATION SUMMARY

Facility Name:				Vendor Number:			
Home Office /Related Management Co.:				Period: From		To	
Line No.	**Account**	**Column 1 Per General Ledger**	**Column 2 Adjustments**	**Column 3 Directly Related Expenses This Facility**	**Column 4 Directly Related Expenses Other Facilities**	**Column 5 Expenses to be Allocated**	**Column 6 Allocated Expenses**
2	**EXPENDITURES**						
2-15	Dues and Subscriptions						
2-16	Education						
2-17	Interest Expense						
2-18	Insurance						
2-19	Legal (Schedule for Col. 3 amount)						
2-20	Rental & Leasing						
2-21	Repairs & Maintenance						
2-22	Supplies & Postage						
2-23	Taxes & Licenses						
2-24	Telephone						
2-25	Travel & Entertainment						
2-26	Utilities						
2-27	Vehicle						
2-28	Other (Attach Schedule)						
2-29	Contributions						
2-30	Income Tax						
2-31	**Total Expenditures**						

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
HOME OFFICE OR RELATED MANAGEMENT COMPANY COST REPORT EXPENSE ALLOCATION SUMMARY

Facility Name:		Vendor Number:	
Home Office /Related Management Co.:		Period: From	To

Line No.			Adjusted Expense
3	**CALCULATION OF ALLOWABLE EXPENDITURES**		
3-01	Expenditures Directly Related to this Facility (Line 2-31, Column 3)		
3-02	Expenditures Allocated to this Facility (Line 2-31, Column 6)		
3-03	Less: Nonallowable Expenses		
	Bad Debts		
	Contributions		
	Income Tax		
	Other (Attach Schedule) Include Vehicles		
	Total Nonallowable Expenses		
3-04	**TOTAL ALLOWABLE EXPENDITURES (To Form 6, Line 2-50, Column 4 and 6)**		

4
PROVIDE A BRIEF DESCRIPTION OF THE METHODS USED TO ALLOCATE EXPENSES TO THIS FACILITY:

STATE OF ARKANSAS
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
LONG-TERM CARE NURSING FACILITY PROVIDERS
STAFFING AND SALARY COSTS

Facility Name

Vendor Number Period: From To

	Account Description	Column 1 Form 6 Line Number	Column 2 Salaries Cost (Form 6, Col. 1)	Column 3 Actual Hours	Column 4 Beginning Hourly Rate
1	Salaries - Aides	1-01			
2	Salaries - LPN's	1-02			
3	Salaries - RN's (exclude DON & Asst. DON)	1-03			
4	Salaries - Assistant Director of Nursing	1-04			
5	Salaries - Director of Nursing	1-05			
6	Salaries - Occupational Therapists	1-06			
7	Salaries - Physical Therapists	1-07			
8	Salaries - Speech Therapists	1-08			
9	Salaries - Other Therapists	1-09			
10	Salaries - Rehabilitation Nurse Aides	1-10			
11	Salaries - Administrator	2-01			
12	Salaries - Assistant Administrator	2-02			
13	Salaries - Dietary Supervisor	2-03			
14	Salaries - Dietary Staff	2-03			
15	Salaries - Housekeeping Supervisor	2-04			
16	Salaries - Housekeeping Staff	2-04			
17	Salaries - Laundry Supervisor	2-05			
18	Salaries - Laundry Staff	2-05			
19	Salaries - Maintenance Supervisor	2-06			
20	Salaries - Maintenance Staff	2-06			
21	Salaries - Medical Records	2-07			
22	Salaries - Other Administrative	2-08			
23	Salaries - Activities	2-09			
24	Salaries - Pharmacy	2-10			
25	Salaries - Social Services	2-11			
26	Salaries - Owner or Owner/Administrator	2-12			
27	Salaries - Non-Working Officer's	5-08			
28	Salaries - Nurse Aide Testing	5-09			
29	Salaries - Nurse Aide Training	5-10			
30	Salaries - Other (Attach Schedule)				
31	Total Salaries				