471-000-41 “Long-Term Care Cost Report” and Instructions.

Completion of Form FA-66, "Long-Term Care Cost Report": All providers participating in NMAP must complete Form FA-66 according to the following instructions. Form FA-66 consists of Schedules "General Data”, A (Parts 1 and 2), B (Parts 1, 2, 3 and 4), B-1, B-2, B-3, B-4, B-5, C, D, (Parts 1, 2 and 3), D-1, E (Parts 1 and 2), E-1, F (Parts 1 and 2), "Preparer Acknowledgement", and "Certification by Officer, Owner or Administrator."

Who Must File: Non-IHS nursing facility providers with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period will not file a cost report. All other long-term care providers located in Nebraska with a long-term care provider agreement with the Department must report its costs on Form FA-66, "Long-Term Care Cost Report."

When to File: The provider must file the cost report within 90 days after:

1. The end of the report period;
2. A change of ownership or management; or
3. Termination from the Nebraska Medical Assistance Program.

What to File: The provider must submit the original signed cost report, including all standard schedules included in the cost report package, all attachments to the schedules, and the preparer's report. A provider who does not need to complete any particular schedule in the report package must mark the schedule as not applicable (N/A).

Where to File: The provider must submit the original signed and completed report to:

Nebraska Department of Health and Human Services
Fifth Floor – Audit Unit
301 Centennial Mall South
P. O. Box 95026
Lincoln, NE 68509-5026

Completion Parameters: The preparer must complete the report within the following parameters set for consistency in the report process:

1. Round all dollar values to the nearest dollar. DO NOT report the cents.
2. Round all percentages to the nearest hundredth of a percent (.80005=80.01%).
3. If additional lines are needed, reference an attachment and include a summary figure on the standard report form.
4. Report only one amount in an entry area.

Completion Procedure: The individual preparing the report must complete the schedules for the report as described in the instructions. The following paragraphs provide a suggested order for completion of the report. Detailed instructions for each section/schedule are located following this summary section.

Complete all the items in the GENERAL DATA schedule.

Determine the license and certification levels at the beginning and the end of the report period. Obtain license changes issued by DHHS Regulation & Licensure during the report period. Obtain certification changes issued by the Department during the report period.

Complete SCHEDULE A, PART 1.

Obtain the monthly detailed census records. Identify any adjustments needed for the cost report.

Complete SCHEDULE A, PART 2.
Obtain the prior year's cost report and any adjustments made subsequent to its completion. Obtain the adjusted trial balance from the provider's accounting records.

Complete: SCHEDULE B, PART 1, COLUMN B
SCHEDULE B, PART 2, COLUMN B
SCHEDULE B, PART 3, COLUMN B
SCHEDULE B, PART 4, COLUMN B
SCHEDULE C

Review the General Cost category on Schedule B, Part 3, and determine if cost adjustments are needed to reclassify payroll taxes or employee benefits.

Complete SCHEDULE B-1 to adjust the general cost category.

Review the costs to determine any other costs that need to be adjusted between cost centers and/or account descriptions to reflect the correct report classification.

Record the reclassification adjustments on SCHEDULE B-4. Use the blank space provided for other adjustments.

Review the costs in the operating and ancillary categories, considering the reclassification adjustments, and determine if any of the costs are the result of transactions with related organizations.

Complete SCHEDULE B-2, if any of the costs are with related organizations.

Review the payroll costs, considering the reclassification adjustments and determine if any of the payroll is paid to owners, directors, or other related parties.

Obtain job descriptions for all owners, directors, or other related parties who received compensation.

Complete SCHEDULE B-3 if any of the payroll includes payments to owners, directors, or related parties.

Review the revenue and cost and determine if any other operating or ancillary costs are included that cannot be considered for reimbursement. Determine how to make the necessary changes for reimbursement -

- offset of the related revenue,
- direct cost adjustment, or
- allocation of the costs.

Record revenue offsets on: SCHEDULE B, PART 1, Columns C & D
SCHEDULE B, PART 2, Columns C & D

Record direct cost adjustments on SCHEDULE B-4. Use the defined lines when possible. Use the blank lines for other adjustments.

Note any items to be allocated. Allocations are completed later in the report process.

Obtain copies of the signed leases if amounts are reported for fixed long-term leases.

Review the leases and determine if any adjustments are necessary for leases not related to the long-term care portion of the facility.

Record the adjustments on SCHEDULE B-4. Use the blank lines provided for other adjustments.
Complete SCHEDULE F, PART 1, lines 1 through 5 for all remaining fixed long-term lease costs.

Complete SCHEDULE F, PART 2 for each lease that may involve ownership cost adjustments.

Complete SCHEDULE F, PART 1, lines 6 through 18. Transfer total lease adjustment data to the other schedules as indicated on the form.

Obtain an itemized depreciation schedule if depreciation is included in the reported cost.

Complete SCHEDULE D, PART 1, Columns B and C.

Review the assets listed on the detailed depreciation schedule and determine if any adjustments are necessary to remove assets not used in the long-term care program or to adjust the cost bases for Medicaid reimbursement.

Report the fixed asset cost adjustments on SCHEDULE D-1.

Summarize the Schedule D-1 adjustments on SCHEDULE D, PART 1, Column D.

Complete the remainder of SCHEDULE D, PART 1. Transfer the adjustment from Line 30 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE D, PART 2 if any assets have been added to the long-term care value during the report period.

Complete SCHEDULE D, PART 3 if any assets have been removed from the long-term care value during the report period.

Obtain copies of signed loan agreements if interest is included in the reported cost.

Complete SCHEDULE E, PART 1, Columns A, B, C, D, E, and F.

Review the loan agreements and determine if any adjustments are needed to remove loans not related to long-term care or to change the loans to amounts allowable for Medicaid reimbursement.

Report the loan adjustments on SCHEDULE E-1.

Summarize the Schedule E-1 adjustments on SCHEDULE E, PART 1, Column G.

Complete the remainder of SCHEDULE E, PART 1. Transfer the adjustments from Line 11 to SCHEDULE B-4 as indicated on the form.

Complete SCHEDULE E, PART 2. Transfer the adjustment to Schedule B-4 as indicated on the form.

Summarize the revenue offsets (Schedule B, Parts 1 and 2) on SCHEDULE B, PART 3, Column C.

Summarize the cost adjustments (Schedule B-1, B-2, B-3, and B-4) on SCHEDULE B, PART 3, Column D.

Complete SCHEDULE B, PART 3, Column E.

Review the costs for allocation and determine the appropriate allocation basis for each line. Obtain the statistical records maintained by the provider.

Complete SCHEDULE B-5. Report only the statistics needed to complete the allocations.

Complete SCHEDULE B, PART 3, Column F. EACH LINE WITH AN AMOUNT TO ALLOCATE MUST HAVE A SCHEDULE B-5 ALLOCATION BASIS NUMBER RECORDED IN COLUMN F.

Complete SCHEDULE B, PART 3, Columns G and H.

Review all the information contained in the report. Make sure that all schedules are completed and that the information is correct.

The preparer completes the "Preparer Acknowledgement" at the end of the report packet and attaches the preparation report.

The owner, officer, or administrator authorized to act on behalf of the provider must review the report and complete the certification.

ALL REPORTS MUST BE SIGNED BY THE PROVIDER MANAGEMENT.

General Data

Description: The General Data Section, located on page 1 of the report form, is used to report information about the provider, the cost report, and the accounting records.

Definitions: Definitions of the information requested on of the General Data section follow.

1. Provider Number - Report the Medicaid long-term care provider number assigned to the nursing facility. If the number changed during the report period, report the provider number in effect at the end of the period. Include one character in each field of the entry area. All fields, including the two digit suffix, must be completed.

2. Mailing Address - Report the commonly used facility name and the address used to receive mail for the facility.

3. Location Address - Report the street address if it is not used in the mailing address.

4. Telephone Number - Report the telephone number for the facility. If the facility has more than one number, include the number of the administrative offices.

5. Location in an Urban Area - Mark the appropriate box:

   YES, if the facility is located in Douglas, Lancaster, Sarpy, or Washington County.
   NO, if the facility is located in any other county.

6. Licensed as - Mark the box that applies to the facility:

   NURSING FACILITY, if the facility is licensed by DHHS R & L as a Nursing Facility.
   HOSPITAL, if the facility is licensed by DHHS R & L as a hospital.

7. Long-term Care Certified for - Mark the box or boxes that apply at any time during the report period:

   NF, if the facility had any or all beds certified for nursing facility only.

   Waivered - Mark the box that applies to the facility:

   YES, if the facility was waivered at any time during the report period.

   NO, if the facility was not waivered at any time during the report period.

ICF/DD, if the facility had any or all beds certified as an intermediate care facility for persons with developmental disabilities.

8. Type of Control - Mark the box that describes the provider's organizational structure. The choices are self-explanatory.

9. Medicare Participation - Mark the boxes that apply:

   YES, if the facility participates in the Medicare Part A and/or Part B program.
   NO, if the facility does not participate in the Medicare program.

   If yes was marked, report the provider number assigned for participation in the Medicare program and the fiscal intermediary for the Medicare program.

10. Report Period - Report the beginning and the ending dates of the period covered by the cost report. Include a character in each field of the entry area. Use leading zeros when needed.

    Example: 07:01:12 to 06:30:13 for report period ended June 30, 2013.

11. Report Type - Mark the boxes that apply:

    REGULAR REPORT PERIOD, if the report is for a full report period of July through the following June.

    CLOSING, if the report period includes the date NF services or participation in the NMAP discontinued at the facility.

    OPENING, if the report period includes the date NF services or participation in the NMAP started at the facility.

12. Facility Regular Fiscal Year - Report the annual period used in the provider's normal course of business. It may be different than the report period used for the Nebraska Long-Term Care Cost Report.

13. Central Office for Chain Providers - If the provider is an entity of a chain of providers, report the central office name, address, and telephone number. If applicable, also include the name of the person in the central office responsible for or most familiar with coordination with the Medicaid programs.

14. Accounting Records Maintained at - Report the name, address, and telephone number of the office where the major portion of the provider's accounting records are located. If this is the same as another address reported in the General Data section, a reference to that item number may be reported rather than repeating the information.

15. Accounting Firm and Representing Accountant - Report the name, address, and telephone number of any accountant or accounting firm used by the provider for accounting, auditing, report preparation, or other activity related to the financial records of the provider. Also report the name of the individual at the firm most familiar with the work done for the provider.

16. Does the facility have an annual certified audit? Mark the box that applies:

    YES, if the provider's financial records for any portion of the report period were included in a certified audit conducted by a licensed certified public accountant.
    NO, if the provider's financial records have not been audited by a licensed certified public accountant.

    Complete all boxes in the General Data Section. If a particular item does not apply to the provider, mark that item as not applicable (N/A). If more space is needed for an item write "See Attachment ##" and report the information on an attached sheet.

17. Facility e-mail – for contact purposes, list the facility's e-mail address.

Schedule A, Occupancy Data, Description: Schedule A is a two-part schedule located on pages 1 and 2 of the report form.

Schedule A, Part 1, Required Occupancy, Description: Part 1, located on page 1 of the report form, is used to report the provider's long-term care licensure and certification information for all days during the report period. It includes space to report any changes that occurred during the period.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

A Period Covered - Report the period that each license or certification level was in effect. The first date entered is the first day of the report period. The last date entered is the last day of the report period. Report each change as it was approved by DHHS R & L. Display entries in this column as month, day, and year (example: July 1, 2012 is displayed 7/1/12).

B Days Covered - For each "period covered" entered in Column A, compute the number of days that the licensure/certification was in effect. The total of all lines will be 365 for a full report period (366 for leap years).

C Number of Licensed Beds Certified for NF Services - Report the long-term care beds licensed and certified for nursing facility services.

If additional lines are needed, mark "See Attachment ##", report the information on the attached sheet, and transfer the total of Columns B from the attachment to the form.

Schedule A, Part 2, Census Data, Description: Part 2, located on page 2 of the report form, is used to report the patient services provided. Lines 1 through 3 apply to NF services provided and line 4 applies to other services provided at the facility.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule A.

A Month - Sets the order for reporting monthly information. Use only the months covered by the cost report.

In Columns B through J, the Column titles used in the definition will refer to "Long-term Care Services". Report the requested census data for NF services on Line 1 through 3.

B Long-term Care Services; Private; In-House - Report the number of days that a private resident actually occupied a long-term care bed at midnight. A private resident is responsible for payment of the facility established rate for services provided.

C Long-term Care Services; Private; Hold - Report the number of days that a bed was actually held for a private resident, subject to limitations at 471 NAC 12-011.06B.

D Long-term Care Services; Private; Total - Add Column B and Column C and record the total in this column.

E Long-term Care Services; Nebraska Medicaid; In-House - Report the number of days that a Nebraska Medicaid resident actually occupied a long-term care bed at midnight. A Nebraska Medicaid resident is a resident whose service has been paid by the Department.

F Long-term Care Services; Nebraska Medicaid; Hold - Report the number of days that a bed was actually held for a Nebraska Medicaid resident, subject to limitations at 471 NAC 12-011.06B.

G Long-term Care Services; Nebraska Medicaid; Total - Add Column E and Column F and record in the total in this column.

H Long-term Care Services; Other NF; In-House - Report the number of days that other long-term care residents actually occupied a long-term care bed at midnight. Other long-term care residents include residents for whom services are paid by another State's Medicaid program, Medicare, Veterans, or other programs.

I Long-term Care Services; Other NF; Hold - Report the number of days that a bed was actually held for other long-term care residents, subject to limitations at 471 NAC 12-011.06B.

J Long-term Care Services; Other NF; Total - Add Column H and Column I and record the total in this column.

The titles used for definitions of Columns K through M refer to "Other Than Long-term Care". Report residential or other services (not NF) provided in the long-term care beds.

K Other Than Long-term Care; In-House - Report the number of days that other residents actually occupied a long-term care bed at midnight.

L Other Than Long-term Care; Hold - Report the number of days that a long-term care bed was actually held for other residents.

M Other Than Long-term Care; Total - Add Column K and Column L and record the total in this column.

Add the census days reported on each column of Item 1 and record the totals on Line 2.

Add the days reported on Line 2, Columns D, G and J and record the "Total NF Days" on Line 3. Copy the total from Line 2, Column M to "Total Other Days" on Line 3.

Report census days for services provided in areas not licensed for long-term care, including all hold days, on line 4.

An inpatient day is counted at midnight. Midnight is the end of a day; therefore, count the day of admission and not the day of dismissal. Report one day for an individual admitted and deceased on the same day.

All hold days are reported consistent with the limitations imposed for payment by the Nebraska Medicaid program. Therefore, all resident hold days are limited to 15 per hospital stay and 18 per year for therapeutic home visits, REGARDLESS OF THE NUMBER OF DAYS PAID. (36 therapeutic home visits for ICF/DD residents.)

Schedule B, Revenue and Costs, Description: Schedule B is a four-part schedule located on pages 3 through 15 of the report form.

Schedule B, Part 1, Patient Revenues, Description: Patient Revenues includes four sections: Medicaid LTC Patient Revenues and the Private LTC Patient Revenues sections, located on page 3, and Other Payor LTC Patient Revenues and Other Than LTC Patient Revenues sections, located on page 4. The first three sections are used to report revenue from long-term care services. The fourth section is used to report patient revenues not related to the long-term care program.

This part of the schedule is also used to report any amounts included in the patient revenues which should be used to offset the costs.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - This column provides the description of the information requested. Most account descriptions are on the form. Some description lines are blank to report patient revenue accounts not meeting the account descriptions included. Do not substitute for the account descriptions.

B Facility Trial Balance - Report amounts from the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C Amount to Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long-term care service. Do not report a revenue offset if the actual costs have been identified or adjusted through some other report process to remove the cost from the reimbursable amount. Using revenue offsets is a short cut to removing the corresponding cost. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Part 3 Line Number to Offset - Report the line number from Schedule B, Part 3 where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific cost account.

Nebraska Medicaid Patient Revenues - Report the patient revenues related to residents covered by the Nebraska Medicaid Program. The revenue for services includes ALL payments received from all sources for those residents. Revenue reported in this section is NOT limited to the State payment.

Private LTC Patient Revenues - Report the patient revenues related to long-term care residents who are responsible for independent payment of the provider established rates. Do not report the portion of the Medicaid rate paid by the Medicaid resident. That amount must be included in the Medicaid Revenue section.

Other Payor LTC Patient Revenues - Report the patient revenues related to long-term care residents covered by other long-term care service programs, (i.e., another State's Medicaid, Medicare, Veterans, Hill-Burton, or others) in this section.

Other than LTC Patient Revenues - Report revenue from all other inpatient services in this section. This would include every type of patient service for residents not included in the long-term care revenues. Report other patient revenues not meeting the descriptions on lines 98 through 110. Do not include revenue related to long-term care service on these lines.

Complete all total lines. Report the grand totals on Line 112. Transfer the amount from Column B, Line 112 to Schedule B, part 4, Line 1.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT USE LINES 15 TO 28, 43 TO 56, AND 71-84.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS. If the blank lines are not adequate to report all the accounts from the provider's trial balance, write in "SEE ATTACHMENT ##", list the accounts on the attachment and show the total amounts on the form. All offsets must be reported on the form. Report a line number to offset for each amount to be offset.

If more than one line is to be offset, use the blank lines, reference the source line in the account description column, and record the offsets in Columns C and D.

Schedule B, Part 2, Other Revenue, Description: Part 2, located on page 5 of the report form, is used to report all other revenue recorded on the provider's trial balance, and any amount in the accounts that should offset cost.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category/Account Description - The column includes descriptions for common revenue accounts. Several lines are blank for other revenue accounts not meeting the descriptions included on the form. Do not substitute for the account descriptions.

B Facility Trial Balance - Report the amount recorded in the provider's trial balance. If a revenue account has a debit balance (a negative revenue) include brackets around the reported amount.

C Amount to Offset Cost - Report any amount included in the revenue which represents a recovery of a cost not related to covered long-term care services. Do not report a revenue offset if the actual costs have been identified and adjusted through some other report process to remove the cost from the reimbursable amounts. Using revenue offsets is a short cut to removing the corresponding costs. The provider must be able to show that the offset used is representative of the corresponding cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

For account descriptions included on the form, two lines are included for reporting offsets related to the revenue. These are provided in order to apply the offset to more than one cost center. If additional lines are needed to complete the offset, use Lines 19 through 46.

D Part 3 Line Number to Offset - Report the Schedule B, Part 3 line number where the offset applies. Part 3 includes lines to apply offsets to categories in total when the offset cannot be applied to a specific account.

If additional lines are needed write "See Attachment ##" in Column A, attach a summary, and record the totals from the attachment on the form. Each amount to be offset must be identified on the form. Therefore, allow space to record the related offsets by line when transferring summary information from the attachment to the form.

Offset unidentified or miscellaneous revenues to Schedule B, Part 3, Line 185.

Add the amounts in Columns B and C and enter the total on Line 47. Transfer amount from Column B to Schedule B, Part 4, Line 2.

DO NOT REPORT MORE THAN ONE AMOUNT IN AN ENTRY AREA.

INDICATE NEGATIVE AMOUNTS WITH BRACKETS.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS.

REPORT A LINE NUMBER TO OFFSET FOR EACH AMOUNT TO BE OFFSET.

Schedule B, Part 3, Costs and Allocations, Description: Part 3, located on pages 6 through 14 of the report form, is used to report all costs from the accounting records. The revenue offsets are summarized. The cost report adjustments are summarized. The allocations to the reimbursable and nonreimbursable cost centers are completed. The provider identifies the reimbursable costs which the Department will use to set the rate.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Line No. - The line numbers provide reference to the account descriptions. They are used in other schedules to relate offsets and adjustments to the appropriate lines of this part of Schedule B. Offsets and adjustments recorded on the other schedules include columns to identify the "Part 3 line number". Use the line numbers from this column to make those references.

Cost Category/Account Description - The cost categories are provided to identify the grouping of the accounts. Because of the various limitations and calculations used in setting rates, COSTS MUST BE REPORTED IN THE PROPER REPORT CLASSIFICATION.

Each category includes several account descriptions. Most categories include blank lines for accounts not fitting the descriptions. In addition, the categories include a line to report costs that are not reimbursable and a line to summarize the category revenue offsets. Do not substitute for the account descriptions on the form. Do not include costs for therapies, other than respiratory, after December 31, 1991.

B Facility Trial Balance - Report the amount from the trial balance for each applicable account description. If the cost account has a credit balance (a negative cost), include brackets to indicate the negative amount.

C Revenue Offsets - Summarize the revenue offsets reported on Parts 1 and 2 of Schedule B. Offsets are normally reductions of the cost. The offsets recorded in this column decrease the cost unless the amount is recorded with brackets.

D Cost Report Adjustments - Summarize the cost report adjustments reported on Schedules B-1, B-2, B-3, and B-4. The adjustments in this column decrease the cost unless the amount is recorded with brackets.

E Cost for Allocation - Subtract the revenue offsets and cost report adjustment amounts from the trial balance amount and record the difference in this column.

F Allocation Basis No. - Record the basis number from Schedule B-5 which is to be used to allocate the amount in Column E. EACH LINE WITH AN AMOUNT IN COLUMN E MUST HAVE AN ALLOCATION BASIS INDICATED IN THIS COLUMN. Use 1 if the entire account is NF, 3 if the account is all nonallowable/other, and 0 if specific accounting is used to identify the cost for the NF or nonallowable/other. Use -0- in this column if the distribution to the cost centers is based on actual costs identified in the records. Allocation methods other than 0, 1, or 3 must be approved by the Department before use. Costs not reported in the proper report classification must use allocation basis 3.

G Allowable Long-term Care - Report the cost distribution for amounts related to the nursing facility. The distribution must be computed according to the allocation basis indicated in Column F. THE AMOUNTS IN COLUMN 'G' MUST REPRESENT ONLY THE NF PORTION OF COSTS ALLOWABLE FOR REIMBURSEMENT.

H Unallowable and Other - Report the cost distribution for amounts not related to NF. The distribution must be computed according to the allocation basis indicated in Column F.

DO NOT SUBSTITUTE FOR THE ACCOUNT DESCRIPTIONS ON THE FORM.

DO NOT REPORT MORE THAN ONE ITEM IN AN ENTRY AREA.

REPORT AN ALLOCATION BASIS NUMBER FOR EACH LINE INCLUDING AN AMOUNT TO ALLOCATE.

Schedule B, Part 4, Revenue and Cost Summary, Description: Part 4, located on page 15 of the report form, is used to summarize the revenue and cost information and report the net revenue or loss for the provider. Most of the information for this part of the Schedule is obtained from other lines in Parts 1, 2, and 3 of Schedule B.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule B.

A Category - The category describes the information to be reported in Column B.

B Amount - Report the corresponding trial balance totals from Parts 1, 2, and 3 or the other information indicated below.

1 Total Patient Revenue - Report the amount from Part 1, Column B, Line 112.

2 Total Other Revenue - Report the amount from Part 2, Column B, Line 47.

3 Total Revenue - Add the amounts on Lines 1 and 2 and report on this line.

4 Administration - Report the amount from Part 3, Column B, Line 34.

5 General - Report the amount from Part 3, Column B, Line 45.

6 Dietary - Report the amount from Part 3, Column B, Line 63.

7 Housekeeping - Report the amount from Part 3, Column B, Line 78.

8 Laundry - Report the amount from Part 3, Column B, Line 93.

9 Nursing - Report the amount from Part 3, Column B, Line 128.

10 Plant - Report the amount from Part 3, Column B, Line 163.

11 Activities and Social Services - Report the amount from Part 3, Column B, Line 184.

12 Total Operating Cost - Add the amounts on Lines 4 through 11 and record the total on this line.

13 Total Ancillary Cost - Report the amount from Part 3, Column B, Line 232.

14 Total Fixed Cost - Report the amount from Part 3, Column B, Line 249.

15 Total Cost Centers-Not Reimbursable - Report the amount from Part 3, Column B, Line 258.

16 Quality Assurance Assessment – Report the amount from Part 3, Column B, Line 259.

17 Total Costs - Add the amounts on Lines 12 through 15 and record the total on this line.

18 Net Income Before Tax - Subtract Line 16 from Line 3 and record the difference on this line.

19 Income Tax Provision - If applicable, report the income tax provision as recorded on the records of the provider.

20 Net Income After Tax - Subtract Line 18 from Line 17 and record the total on this line.

Do not report more than one amount for any one entry area.

Schedule B-1, General Cost Allocation and Adjustment, Description: Schedule B-1, located on page 16 of the report form, is used to complete the allocation of the costs reported in the general cost category.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-1.

A Payroll Category - These are the payroll account descriptions included in Schedule B, Part 3.

B Salaries, Wages, Other Compensation Reported - Report the amounts on this line that are reported for the corresponding account descriptions in Schedule B, Part 3. If any adjustments are made to the salary accounts before completion of this form, include the adjusted amounts in this column.

C Exemption - Report any adjustment to the salary needed to set a reasonable basis for the allocation of the FICA tax. This column relates primarily to situations where individual payrolls have exceeded the maximum used for FICA tax.

D Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column C.

E Percentage - Divide each line of Column D by the total of that column and record the percentage in this column. Round all percentages to the nearest hundredth of a percent.

F Adjustment - Multiply the percentage in Column E by the total FICA tax reported on Schedule B, Part 3, Line 35, and record the result in this column.

G Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

H Exemption - Report amounts in this column needed to adjust the salaries, etc., in Column B to an equitable allocation base for other payroll taxes.

I Allocation Basis - Report the salary, etc., from Column B, adjusted by the amounts in Column H.

J Percentage - Divide each line of Column I by the total of that column and record the percentage in this column.

K Adjustment - Multiply the percentage in Column J by the total other payroll tax reported on Schedule B, Part 3, Line 36, and record the result in this column.

L Line Number to Adjust - The form includes the payroll tax line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

M Percentage - Divide each line of Column B by the total of that column and record the percentage in this column.

N Adjustment - Multiply the percentage in Column M by the allowable benefits included on Schedule B, Part 3, Lines 37 through 43, and record the result in this column.

O Line Number to Adjust - The form includes the fringe benefits line number to adjust. DO NOT MAKE ENTRIES IN THIS COLUMN.

THE TOTAL OF THE ADJUSTMENT COLUMNS MUST AGREE WITH THE CORRESPONDING AMOUNTS IN THE GENERAL COST CATEGORY ON SCHEDULE B, PART 3. NO REIMBURSEMENT IS COMPUTED FOR ANY COSTS REMAINING IN THE GENERAL COST CATEGORY.

Summarize the adjustments from this schedule, along with those from Schedules B-2, B-3, and B-4, in Column D of Schedule B, Part 3.

Schedule B-2, Transactions with Related Organizations, Report and Adjustments, Description: Schedule B-2, located on page 17 of the report form, is used to report ALL related organization transactions included in the operating and ancillary cost categories and to determine the related adjustments.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-2.

A Name of Related Organization or Individual - Report the name of the related organization or the individual.

B Percent of Ownership, Related Organization in Nursing Home - Report what portion of the provider is owned by the related organization.

C Percent of Ownership, Nursing Home in Related Organization - Report what portion of the related organization is owned by the provider.

D Common Owners, Percent Ownership in Nursing Home - Determine the individuals or organizations that have ownership in both the related organization and the provider. Report the total share of the provider owned by those individuals and organizations.

E Common Owners, Percent Ownership in Related Firm - Determine the individuals and organizations that have ownership in both the related organization and the provider. Report the total share of the related organization owned by those individuals and organizations.

F Purchases from Related Organization in the Amount Of - Report the total amount of the transactions with the related organization or individual. Complete one line for each line of Schedule B, Part 3 that includes related party transactions.

G Cost to Related Organization of Services/Items Purchased - Report the original cost to the related organization. If the related organization qualifies for the exception to the limitation, do not report the cost. Instead, write the word "exception" in this column.

H Amount to (Increase) Decrease - Subtract the amount in Column G from the amount in Column F and record the difference in this column. If the exception applies, report zero in this column.

I Line Number - Report the Schedule B, Part 3 line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3 that includes the transaction.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-3, and B-4, in Column D of Schedule B, Part 3.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

Schedule B-3, Compensation of Owners, Directors and Other Related Parties, Report and Adjustment, Description: Schedule B-3, located on page 18 of the report form, is used to report ALL compensation paid to owners, directors, and other individuals related to owners or directors. Compensation includes salary, benefits, and services or items paid by the provider which are for the personal use of an individual. The schedule is used to adjust the compensation paid to owners, directors, and related parties to the amount for reimbursement.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-3.

A Name of Individual - Report the name of every owner, director, or related party who receives compensation from the provider. If the individual holds more than one position, that is, his/her compensation is reported in more than one payroll category on Schedule B, Part 3, use separate report lines on this schedule for each position.

B Position - Report the paid position the individual holds at the facility. Attach specific job descriptions for each position listed.

C Documented Percentage of 40 Hour Work Week - Report the average percentage of a 40 hour week that the individual has DOCUMENTED performance of the duties assigned to the position.

D Percentage Owned - If the individual owns a portion of the provider, report the percentage of ownership in this column. Also, note the relationship, board position, or other reason that the individual is listed on the schedule.

E Account - Record the account descriptions from Schedule B, Part 3 where the compensation is reported. Each line includes space to report five accounts. Three of the spaces relate to payroll, payroll tax, and fringe benefits. Two spaces are provided to report compensation paid in other forms, i.e., automobile, housing, supplies, meals, etc.

F Amount Per Trial Balance - Report the compensation amount reported on Schedule B, Part 3.

G Amount Allowable - Based on the documented services provided, report the reasonable amount of compensation to be allowed. The allowable compensation is the usual amount paid for similar positions at the facility or for similar positions outside the facility. The amounts in this column must not exceed the amounts in Column F for the position.

H Amount to Decrease Cost - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I Line Number - Report the Schedule B, Part 3, line number where the adjustment applies. If there is no adjustment, report the line number from Schedule B, Part 3, that includes the compensation.

Summarize the adjustments from this schedule, along with those from Schedule B-1, B-2, and B-4, in Column D of Schedule B, Part 3.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 20.

Schedule B-4, Other Cost Adjustments, Description: Schedule B-4, located on pages 19 and 20 of the report form, is used to report cost adjustments needed to change the trial balance costs to the amounts allowable for reimbursement.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-4.

A Adjustment Descriptions - Adjustment descriptions are provided on the first page of the schedule. Lines 1 through 17 describe some of the common Medicaid reimbursement adjustments. Lines 18 through 23 describe the fixed cost adjustments determined on other schedules of the report. The descriptions for these six lines include a reference to the adjustment's source schedule.

On the second page of the schedule, the Adjustment Description column is blank. Use these lines to report any other adjustments, increases, decreases, or reclassifications needed to complete the process of revision of the trial balance to the allowable cost for allocation. (Report an adjustment description, not the account description.) DO NOT ENTER MORE THAN ONE AMOUNT IN ANY BOX IN COLUMNS B AND C. DO NOT ENTER MORE THAN ONE LINE NUMBER IN ANY BOX IN COLUMN D.

B Amount to Increase Cost - Report the adjustment amount in this column if it increases the reported cost.

C Amount to Decrease Cost - Report the adjustment amount in this column if it decreases the reported cost.

D Line Number to Adjust - Report the line number from Schedule B, Part 3, where the adjustment amount in Column B and/or C applies.

If a revenue offset has been used to adjust for an unallowable cost, and the revenue offset covers the cost incurred, that cost does not need to have an adjustment on this form.

Summarize the adjustments from this schedule, along with those from Schedules B-1, B-2, and B-3, in Column D of Schedule B, Part 3.

Copies of the second page of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. The multiple use of this form is limited to 100.

Schedule B-5, Statistical Data For Allocations, Description: Schedule B-5, located on page 21 of the report form, is used to report the allocation bases used for the allocation of costs between the NF and other cost centers. The statistics and resulting percentages reported on this schedule are used to distribute the costs on Schedule B, Part 3, Columns G and H.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule B-5.

A Basis No. - The numbers in this column, 0 through 31, are of major importance in the report process. They are used to complete Column F on Schedule B, Part 3, for each line that has cost to allocate.

B Allocation Basis - This column describes the basis used for the allocation. Basis 0 indicates that the provider's records will identify the reported distribution, thus no allocation was necessary. Bases 1 and 3 indicate that 100% of the costs relate to one cost center; NF, or Other, respectively. Bases 4 through 9 are commonly used allocation bases but are not required to be used. The remaining lines are left for the provider to identify other allocation bases selected.

C Statistics for Allocation, Total - Report the total of the statistic base. Report the statistics on the top portion of each basis line. Report the percentage on the bottom portion of each basis line. For this column, the percentage is 100.00%.

D Statistics for Allocation; NF and Other - On the top portion of the basis line report the breakdown of the statistics used for allocation. Compute the percentage each cost center's statistics are of the total statistical base and record the percentage in the bottom portion of the basis line.

ROUND THE PERCENTAGES TO ONE HUNDREDTH OF A PERCENT.

If an allocation basis is more complex than the straight one line statistical basis, write "See Attachment ##" on the description line. Show the statistics and computations used to determine the allocation on the attachment. Record the percentages on both portions of the basis line of the form.

Do not use more bases than the blank lines permit.

Allocation bases used must be consistent from year to year unless a change is approved or directed by the Department.

All allocation bases must be approved by the Department before the Report Period.

Schedule C, Comparative Balance Sheet, Description: Schedule C, located on page 22 of the report form, is used to report the assets, liabilities, and equity of the provider. The schedule includes the prior year and current year information.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule C.

A Assets, Liabilities, and Equity - This column provides the account descriptions for the balance sheet accounts. Some lines have been left blank to add accounts not listed.

B Previous Year Ending - Record this column as it appears on the prior report period's cost report form. Note any variance from the prior year's report in the preparer's report.

C Current Year Ending - Report the current report period's closing balance sheet.

The reported data must reflect the provider's balance sheet. If the provider's balance sheet is part of a consolidation of several entities, the long-term assets and liabilities must be reported for the provider with a balancing intercompany entry for equity. Beginning with the report period beginning July 1, 1986, the provider's portion of the balance sheet must be broken out from the consolidated statement and reported.

Schedule D, Part 1, Depreciation Cost, Description: Schedule D is a three-part schedule located on pages 23 and 24 of the report form.

Part 1, located on page 23 of the report form, is used to report the fixed assets recorded on the trial balance and summarize the adjustments needed to change the trial balance fixed asset cost to include only the nursing facility assets. It is also used to report the appropriate depreciation and to compute the adjustment to correct the trial balance depreciation.

The schedule includes summary data. The depreciation schedule maintained at the facility must provide the detail that identifies each fixed asset and the related depreciation.

Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule D.

A Description of Property - This column provides the identification of the asset groups to be reported. Several asset group titles are on the schedule. Other lines are blank for other groupings according to the trial balance.

B Date Acquired - Report the date that the property was acquired by the provider. This column only needs to be completed on the lines for the original assets.

C Trial Balance - Report the balance sheet cost amount for each of the asset groups. This column must agree with the balance sheet reported on Schedule C.

D Cost Adjustment - The adjustments reported on Schedule D-1 are summarized and reported in this column. The adjustments are considered a cost reduction unless the amount is recorded with brackets.

E Cost, Long-term Care Value - Subtract the cost adjustments in Column D from the trial balance amounts in Column C and record the difference in this column.

F Salvage Value - Report any salvage value expected at the end of the assigned useful life.

G Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.

H Useful Life - The useful lives assigned for reimbursement purposes must follow the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition (see 471 NAC 12-011.09). (IRS accelerated cost recovery system lives do not qualify for "depreciation" for Medicaid reimbursement purposes.) Report lives as years.

I Not used on this part of the schedule.

J Prior Years Depreciation - Report the accumulated depreciation as of the beginning of the report period. Report the amount based on Medicaid values.

K Depreciation Cost - Report the depreciation for the report period. Subtract the amount in Column F from the amount in Column E and divide the difference by the assigned life. For partial years, prorate the annual amount.

L Medicaid Book Value - The long-term care cost value minus the accumulated Medicaid depreciation cost for the assets that remain in use at the end of the report period.

Transfer the cost of leased items from Schedule E, Part 1 to Line 27. Add amounts in each column and record the totals on Line 28. Transfer the depreciation cost from the trial balance to Line 29 of Column K. The trial balance depreciation cost is reported on Schedule B, Part 3, Column B, Line 233. In Column J, subtract the amount reported on Line 29 from the amount reported on Line 28 and record the difference on Line 30. Transfer this amount to Schedule B-4 as indicated on the form.

Schedule D, Part 2, Cost Report Period Additions, Description: Part 2, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets added during the report period.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A Item Description - Report the specific description of the asset that has been added. This may not be reported in summary form except when identical assets are purchased in one lot on the same day. In such a case, include the number of items.

B Date Acquired - Report the date that the item was purchased or acquired.

C Not used in this part.

D Useful Life - Report the useful life used for Medicaid reimbursement purposes.

E Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight-line method.

F Original Cost - Report the asset cost included in Column E of Part 1 as a result of acquisition of the fixed asset.

G Salvage Value - Report any salvage value expected at the end of the assigned useful life.

H Current Year Depreciation Cost - Report the depreciation as computed for Medicaid purposes. Subtract the salvage value, Column G, from the original cost, Column F, and divide by the number of years useful life, Column D. For partial years, prorate the annual amount.

I Not used for this part.

J Schedule D, part 1, Line Number - Report the line number where the new addition is included on the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the total on the total line.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

FIXED ASSET ADDITIONS MUST BE REPORTED ON THIS PART OF THE SCHEDULE IN ORDER FOR DEPRECIATION TO BE ALLOWED.

Schedule D, Part 3, Current Report Period Deletions, Description: Part 3, located on page 24 of the report form, is used to report the depreciation schedule information for fixed assets removed from long-term care during the report period.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by additional information about this part of Schedule D.

A Item Description - Report the specific description of the asset that has been removed from service. Each item must be identified separately.

B Date of Acquisition - Report the date the fixed asset was originally acquired.

C Date of Disposal - Report the date the item was no longer used for long-term care.

D Useful Life - Use the American Hospital Association guidelines to determine useful lives.

E Depreciation Method - The form indicates SL for straight line. For reimbursement purposes, depreciation must be reported using the straight line method.

F Original Cost - Report the asset cost used for Medicaid depreciation.

G Salvage Value - Report the amount that had been carried on the depreciation schedule as the salvage value.

H Current Year Depreciation Cost - Report the depreciation from the beginning of the report period to the date that the asset was no longer in use for long-term care.

I Accumulated Depreciation - Report all depreciation which has accumulated from the date of acquisition to the date the time was removed from service for long-term care.

J Schedule D Part 1 Line Number - Report the line number where the item removed will be deleted from the Depreciation Schedule Summary, Schedule D, Part 1.

Add all amount columns and record the totals on the total line.

FIXED ASSET DELETIONS MUST BE REPORTED ON THIS SCHEDULE IN ORDER FOR THE PAST DEPRECIATION TO BE ALLOWABLE.

Copies of this part of the schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the page.

Schedule D-1, Depreciation Schedule Adjustments, Description: Schedule D-1, located on page 25 of the report form, is used to itemize and describe the adjustments used to adjust the facility trial balance fixed asset cost to the amount allowed. It is also used to make adjustments to reclassify fixed asset categories.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule D-1.

A Adjustment Description - Report the reason for each adjustment. Do NOT report only the item description or property category to be adjusted.

B Amount to Increase Cost - Report the adjustment amount to increase the fixed asset cost on Schedule D, Part 1.

C Amount to Decrease Cost - Report the adjustment amount to decrease the fixed asset cost on Schedule D, Part 1.

D Schedule D Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number on Schedule D, Part 1 that is to be adjusted.

After completing the adjustments, summarize the adjustments on Schedule D, Part 1, Column D.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

Schedule E, Interest Cost, Description: Schedule E is a two-part schedule located on pages 26 and 27 of the report form.

Schedule E, Part 1, Loans and Interest Cost Summary, Description: Part 1, located on page 26 of the report form, is used to report the loan information for all loans included on the trial balance and adjustments needed to change the trial balance to include only the allowable loans. It is also used to determine the adjustments necessary to adjust the trial balance interest cost to the amount allowable for reimbursement.

Definitions: Definitions of the data requested on this part of the schedule follow. Column definitions are followed by other information about this part of Schedule E.

A Source/Security and Purpose - This column includes three items of information for each loan:

Source - Report the lending institution or individual who made the loan to the provider. If the loan is a bond issue, report the type of bond issue (i.e., revenue bonds, industrial development bonds, etc.).

Related Parties (X) - Mark this box if the source of the loan is related to the provider through common ownership or control as defined by the regulations.

Security and Purpose - Report the security pledged for repayment (i.e., mortgage, real property (describe), or personal property (describe), or as a "signature loan"). REPORT THE PURPOSE OF THE LOAN (i.e., to finance purchase of assets, to provide operating funds, to build an addition, to pay taxes, etc.). If additional space is needed to report the security and purpose, include the information on an attachment.

B Date of Origin/Date Mature - This column includes two items of information for each loan:

Date of Origin-Report the date the loan was obtained.
Date Mature-Report the date that the loan becomes due or the date the final installment is due.

C Original Loan Amount - Report the amount borrowed at the Date of Origin. If the loan has a floating balance such as a line of credit, report the highest balance for the report period.

D Interest Rate - Report the interest rate as specified in the conditions of the loan. In cases of variable interest loans, mark a "V" in the box at the left of the column and report the final rate effective for the report period.

E Adjusted Beginning Balance - Report the loan balances as they appeared on the prior year cost report "Adjusted Ending" column. If the loan originated during the report period, enter -0- in this column.

F Ending Loan Balance - Report the loan amount as they appear on the trial balance. If a loan was paid off during the report period, report -0- in this column.

G Adjustments - The loan balance adjustments reported on Schedule E-1 are summarized and reported in this column. The adjustments are considered a loan reduction unless the amount is recorded with brackets.

H Adjusted Ending - Subtract the amount in Column G from the amount in Column F and record the difference in this column.

I Not used on this part of the schedule.

J Interest Cost, Paid to Unrelated Parties - Report the allowable interest in this column. If the full interest amount for a loan is not allowable, report the allowable portion in this column. The unallowable portion is reported in Column L.

K Interest Cost, Paid to Related Parties - Report the interest paid and/or accrued on the loans from parties related to the provider by common ownership or control. The loan balance for these loans are included in the adjustments in Column G.

L Interest Cost, Non-Nursing Facility Operations - Report the interest paid and accrued on loans which are not related to the nursing facility. The loan balances for these loans are included in the adjustments recorded in Column G. Also report the unallowable portion of the interest cost for loans which are otherwise allowable.

Transfer the lease cost information from Schedule F, Part 1, to Line 10. Add the amount columns and record the totals on Line 11. Provide a breakdown of the loans, as indicated, for Lines 12, 13, and 14.

Transfer the totals of Columns K and L to Schedule B-4 as indicated on the form.

Copies of this form may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule. If additional copies are used, record the total for ALL copies on the last copy. Do not complete Lines 10 through 14 except on the final copy.

Attach one copy of the signed loan agreement for all loans originated or refinanced during the Report Period.

Schedule E, Part 2, Interest Limitation Computation, Description: Part 2, located on page 27 of the report form, is used to compute the interest limitation required when interest bearing loans exceed 80% of the cost of the fixed assets used for patient care. Two options are available for the computation. Option 1 bases the limitation on the year end loan and asset balances. Option 2 bases the limitation on monthly balances. A provider may change from Option 1 to Option 2 for any report. After Option 2 is selected for any report period, it must be used for all subsequent reports, unless a change is approved by the Department.

Government-operated providers do not need to complete Part 2. They are not subject to the limitation. (Government operated providers MUST complete Part 1.)

Definitions: Definitions of the data requested on this part of Schedule E follow:

OPTION 1: ANNUAL AVERAGE - The definitions are given for each line.

1. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form.

2. Record the trial balance asset cost from Schedule D, Part 1, Column C, Line 28.

3. Record the asset cost adjustments from Schedule D, Part 1, Column D, Line 28.

4. Add Line 2 to Line 3 and record the total on this line. The amount should equal Schedule D, Part 1, Column E, Line 28.

5. Multiply the amount on Line 4 by 0.80 and record the result on this line.

6. Subtract the amount on Line 5 from the amount on Line 1 and record the difference on this line. If the amount is zero or a negative amount, do not complete the remainder of the form. If it is a positive amount, continue with Line 7.

7. Record the beginning loan balance from Schedule E, Part 1. The line reference is indicated on the form.

8. Record the ending loan balance from Schedule E, Part 1. The line reference is indicated on the form. (This is the same as the amount on Line 1.)

9. Compute the average loan balance. Add the amount on Line 7 and the amount on Line 8 and divide the total by 2. Record the result on this line.

10. Record the interest paid to unrelated parties from Schedule E, Part 1. The line reference is indicated on the form.

11. Compute the average annual interest rate. Divide the amount on Line 10 by the amount on Line 9. Record the result on this line.

12. Compute the amount of the limitation. Multiply the rate from Line 11 by the amount on Line 6. Transfer the limitation to the Schedule B-4 as indicated on the form.

OPTION 2 - MONTHLY AVERAGE - The definitions for the columns are followed by additional information about Option 2.

A Date - This column indicates the date that loan information and limitations are to be calculated. If the report is completed for less than the full 12 months, complete only the applicable months. Report the beginning amounts for a report period on Line 1, even if starting on another date. Write the correct beginning date on the line.

B Total All Interest Bearing Loans - Report the total loans that accrue interest.

C Total Related Party Interest Bearing Loans - Report the loans with related parties included in the amount reported in Column B.

D Total Non-Nursing Home Loans - Report the loans not related to the long-term care which are included in Column B.

E Allowable Loan Balances - Add the amount in Column C to the amount in Column D. Subtract the total from the amount in Column B. Record the result in this column.

F Cost of Fixed Assets Related to Care - Report the net allowable fixed asset cost after adjustments as determined for Medicaid reimbursement.

G 80% of Asset Cost - Multiply the amount in Column F by 0.80 and record the result in this column.

H Loan Balance Over 80% of Asset Cost - Subtract the amount in Column G from the amount in Column E and record the difference in this column. IF THE RESULT IS NEGATIVE, REPORT -0-, NOT THE NEGATIVE AMOUNT.

I Average Interest Rate - Complete Lines 14 through 18 as follows:

14 Add amounts in each column and record the total on this line.

15 Compute the average monthly loan balance. Divide the amount from Column E, Line 14, by the number of dates reported. Record the result on this line in Column E. Also record the result on Line 17.

16 Record the interest paid to unrelated parties as determined on Schedule E, Part 1. The line reference is indicated on the form.

17 Record the amount from Column E, Line 15 on this line.

18 Compute the average rate of interest. Divide the amount on Line 16 by the amount on Line 17. Record the total on this line.

Record the average rate of interest from Line 18 on all lines of Column I.

J Interest Adjustment - Compute the interest limitation for the month. Multiple the amount in Column H by the rate in Column I. Divide the result by the number of months covered by the cost report and record the result in this column.

Add the amounts in Column J and record the total on Line 14. Also record the result on Schedule B-4 as indicated on the form.

Use of Option 2 requires the provider to maintain detailed accrual records on a monthly basis.

Schedule E-1, Loan Schedule Adjustments, Description: Schedule E-1, located on page 28 of the report form, is used to itemize and describe the adjustments used to adjust the ending loan balances to the amounts used for reimbursement.

Definitions: Definitions of the data requested on the schedule follow. Column definitions are followed by other information about Schedule E-1.

A Adjustment Description - Report the reason for each adjustment in this column. Do NOT report only the loan source to be adjusted.

B Increase of Loan Amount - Report the adjustment amount to increase the loan amount on Schedule E, Part 1.

C Decrease of Loan Amount - Report the adjustment amount to decrease the loan amount on Schedule E, Part 1.

D Sch. E Part 1 Line to Adjust - For each adjustment increase and/or decrease reported in Columns B and C, report the line number from Schedule E, Part 1 which is to be adjusted.

After completing the adjustments, summarize the adjustments and record the totals on Schedule E, Part 1, Column G.

Copies of this schedule may be used to expand the number of lines as needed. Record the copy number in the box at the bottom of the schedule.

Schedule F, Leases, Description: Schedule F is a two-part form located on pages 29 and 30 of the report form.

Schedule F, Part 1, Leases and Lease Adjustments, Description: Part 1, located on page 29 of the report form, is used to report information regarding all fixed long-term leases included in the provider's fixed costs. The information reported on Line 5 determines if Part 2 and the remainder of the column is completed for any lease. This part also summarizes information from all copies of Part 2 and the resulting adjustments.

Definitions: Definitions of the data requested for this part of the schedule follow. Line definitions are followed by other information about this part of Schedule F.

1 Assigned Lease Number - Chronologically number the columns used to report on the leases. One column must be completed for each lease agreement.

2 Leasing Company or Individual - Report the name of the lessor as it appears on the lease agreement.

3 Items Leased - Describe the leased item or items. If the lease covers many items, use a summary description.

4 Cost Included on Trial Balance - Report the amount included in the lease costs reported on Schedule B, Part 3. (Do not report non-nursing facility leases. Such leases should be removed from the trial balance amount by adjustments on Schedule B-4.)

5 Mark the first line, 5a through 5e, which applies to the lease.

5a Related Organization - Mark the line if the lessor is related to the provider through common ownership or control as defined in the regulations.

5b Facility Leased after 7/31/82 - Mark this line if the lease agreement is subject to limitation according to 471 NAC 12-011.06E. The regulation refers to facilities leased after July 31, 1982.

5c Lease Purchases - Mark this line if the lease agreement is a lease/purchase agreement as defined in the Provider Reimbursement Manual HIM-15, Section 110.

5d Sale and Lease Back - Mark this line if the lease agreement involves a sale and lease back by the seller.

5e Other - Mark this line if 5a, 5b, 5c, and 5d do not apply to the lease.

If 5a, 5b, 5c, or 5d is marked, Part 2 must be completed for the lease. Part 2 must be completed before Lines 6 through 18 can be completed for the lease.

If line 5e is marked, do not complete Part 2 or lines 6 through 18.

Lines 6 through 18 summarize information on leases subject to ownership cost limitations. Develop the data for an individual lease by completing Part 2.

6 Cost to Reduce, Building and Perm. Equipment Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2, which is for building and permanent equipment.

7 Cost to Reduce, Vehicle Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for a vehicle.

8 Cost to Reduce, Other Long-term Lease - If the owner's cost is substituted for the lease, record the amount from Part 2, Item 2 that is for other long-term leases.

9 Cost to Allow, Depreciation - If the owner's cost is substituted for the lease, record the total depreciation amount from Part 2, Item 4.

10 Cost to Allow, Interest - If the owner's cost is substituted for the lease, record the total interest amount from Part 2, Item 5.

11-15 Cost to Allow, Other - If the owner's cost is substituted for the lease, record the other amounts by account description from Part 2, Item 6.

16 Other Ownership Data, Asset Cost - If owner's cost is substituted for the lease, record the total asset cost from Part 2, Item 4.

17 Other Ownership Data, Beginning Loan Balance - If owner's cost is substituted for the lease, record the total beginning balance from Part 2, Item 5.

18 Other Ownership Data, Ending Loan Balance - If owner's cost is substituted for the lease, record the total ending balance from Part 2, Item 5.

After completing all leases, add the amount lines and record the total in the last column of the last copy of Part 1. Also record the totals from Lines 6 through 18 on the other schedules as indicated at the end of each line on the form.

If any lease was originated, renegotiated, or otherwise changed during the Report Period, include one copy with the submitted reports.

This part of the schedule may be copied to expand the number of columns as needed. Record the copy number in the box at the bottom of the page.

Schedule F, Part 2, Ownership Cost, Description: Part 2, located on page 30 of the report form, is used to report information on each lease which may be subject to the ownership cost limitations. The use of this part depends on which item is marked on Schedule F, Part 1, Line 5. A short outline on the form indicates how to report the cost information for each of the four options. Complete this part for each lease marked on Schedule F, Part 1, Line 5a, 5b, 5c, or 5d. Copy the page as needed to report on subject leases.

Definitions: Definitions of the data requested for each item of this part of Schedule F follow.

1 Record the lease number assigned to this lease from Part 1, Line 1.

2 Record the cost reported for this lease. The amount will agree with the amount reported on Part 1, Line 4.

3 Complete only when 5b is marked on Part 1. Mark yes or no for each question. The three items are required for any cost to be allowed for a facility or facility/equipment lease entered into after July 31, 1982. If ANY of the questions are answered no, report -0- for all the totals in Items 4, 5, and 6. If ALL are answered yes, complete Items 4, 5, and 6.

4 Depreciation Schedule - Report the depreciation schedule data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

5 Loans and Interest - Report the loan data for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

6 Other Costs - Report any other costs for the leased items based on the ownership data. Report amounts allowable for Medicaid reimbursement.

Depending on the basis for completion of Part 2, transfer the totals and other amounts to Part 1, Lines 6 through 18.

Preparer Acknowledgement, Description: The preparer acknowledgement is located on the last page of the report form. This part must be completed by any person or firm that prepares the cost report. The acknowledgement, in and of itself, is not a "report" on the statements of the cost report. Reports issued by the preparer are part of the cost report and must be attached to the cost report.

The preparer of a cost report must be familiar with the Nebraska Medicaid reimbursement program and the long-term care industry accounting principles and practices. The preparer must discuss potential disallowances with the provider's management. The preparer must, in the preparer's report, disclose known variances from the reporting and regulatory requirements included in the cost report preparation.

Instructions: Record the following information in the blanks:

- the "official" name of the provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.

- the provider number assigned by the Department.

If the preparer is a certified public accountant or accounting firm, indicate the type of report issued on the engagement.

Signature - The preparer signs the acknowledgement. Also print or type the name of the individual signing the acknowledgement.

Firm - Report the name of the firm contracted to prepare the report.

Date - Report the date the acknowledgement is signed.

Certification of Officer, Owner, or Administrator, Description: The certification is located on the last page of the report form. It is used by the provider's management to attest to the accuracy of the cost report information provided to the Department. The person signing the report must be familiar with the Nebraska Medicaid Program's reimbursement regulations and the provider's costs. The person signing the report indicates by signature, that she/he has reason to know what is included in the report and what cannot be included in the report.

Instructions: Record the following information in the blanks:

- the "official" name of the long-term care provider organization, the name that appears on the current Nebraska Medicaid Provider Agreement.

- the provider number assigned by the Department.

- the beginning and ending date of the period covered by the cost report.

Signature - The provider's owner, officer, or administrator signs the report. Also type or print the name in this box.

Title - Report the title of the individual signing the report.

Date - Report the date the report is signed.

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid & Long-Term Care
Long-Term Care Cost Report
Medical Assistance Program

GENERAL DATA

1. Provider Number

2. Mailing Address:

Facility

Street, P.O. Box, Route

City State Zip

3. Location Address (If not as above):

Street

4. Telephone:

(Area Code) Number

5. Location in Metropolitan Statistical Area:
☐ Yes ☐ No

6. Licensed as:
☐ Nursing Home ☐ Hospital

7. Long-term Care Certified for:
☐ Nursing Facility (NF) ☐ ICF/MR
(Waivered ☐ Yes ☐ No)

8. Type of Control:

Government: ☐ City ☐ County ☐ District ☐ State ☐ Federal

Proprietary: ☐ Individual ☐ Partnership ☐ Corporation

Non-Proprietary: ☐ Voluntary Non-Profit

9. Medicare Participant:
☐ Yes ☐ No Part A
☐ Yes ☐ No Part B
If Yes:

Medicare Provider Number

Intermediary

10. Report Period:

Mon. Day Year to Mon. Day Year

11. Report Type:
☐ Regular Report Period (July to June)
☐ Closing (July 1 to Close)
☐ Beginning (Open to June 30)

12. Facility Regular Fiscal Year _____ to _____

13. Central Office for Chain Providers:

Reimbursement Officer

Address

Telephone #

14. Accounting Records Maintained at:

Address

Telephone #

15. Accounting Firm

Accountant

Address

Telephone #

16. Does the facility have an annual certified audit?
☐ Yes ☐ No

17. Facility e-mail

INSTRUCTIONS: Complete the LONG-TERM CARE COST REPORT according to the instructions found in the Nebraska Department of Health and Human Services Medicaid & Long-Term Care Manual at Title 471 NAC 12-012.

MAILING INSTRUCTIONS: Complete, sign and mail the ORIGINAL of this report to the Nebraska Department of Health and Human Services, Audit, 301 Centennial Mall South, P.O. Box 95026, Lincoln, Nebraska 68509-5026.

PREPARATION ASSISTANCE: Contact the Long-term Care Audit at (402)-471-9250.

SCHEDULE A
OCCUPANCY DATA

PART 1: Required Occupancy

	A	B	C
	Period covered	Days covered	Number of licensed beds certified NF
1.	/ / to / /		
	/ / to / /		
	/ / to / /		
	/ / to / /		
	/ / to / /		
	/ / to / /		

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(Previous version 4/11 should NOT be used)

Schedule A
Occupancy Data

PART 2: Census Data

	A	Nursing Facility Services									Other Than Long-Term Care in NF Certified Beds		
		Private			Nebraska Medicaid			Other NF (V.A. Etc.)					
	Month	In-House Only	Bed Hold Only	Total Days	In-House Only	Bed Hold Only	Total	In-House Only	Bed Hold Only	Total	In-House Only	Bed Hold Only	Total
1.	July												
	August												
	September												
	October												
	November												
	December												
	January												
	February												
	March												
	April												
	May												
	June												
2.	TOTALS												

3. Total NF Days _____ Total Other Days _____

4. Total days provided in assisted living, apartment, residential, custodial, domiciliary or other areas NOT certified for Long-Term Care _____

Schedule B
Revenue and Costs
PART 1: Patient Revenues
Nebraska Medicaid LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
1	Room, Board and Routine Services			
2	Other Routine Charge			
	Ancillary Charges –			
3	– Physical Therapy			
4	– Occupational Therapy			
5	– Other Therapy			
6	– Patient Transportation			
7	– Programmatic Evaluation			
8	– Other Covered Ancillary			
9	Program Charge Allowance			
10				
11				
12	Total Revenue – Covered Services			
13	NF Revenue From Ancillary Services Not Covered by LTC Program			
14	Total NF Revenue			
	Lines 15-28 not used			

Schedule B
Revenue and Costs
PART 1: Patient Revenues
Private LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
29	Room, Board and Routine Services			
30	Other Routine Charge			
	Ancillary Charges –			
31	– Physical Therapy			
32	– Occupational Therapy			
33	– Other Therapy			
34	– Patient Transportation			
35	– Programmatic Evaluation			
36	– Other Covered Ancillary			
37	Charity and Courtesy Allowances	( )		
38	Bad Debts	( )		
39	Other Revenue Deduction	( )		
40	Total Revenue – Covered Services			
41	NF Revenue From Ancillary Services Not Covered by LTC Program			
42	Total NF Revenue			
	Lines 43-56 not used			

Schedule B
Revenue and Costs

PART 1: Patient Revenues

Other Payor LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	NF Revenue From Covered Services:			
57	Room, Board and Routine Services			
58	Other Routine Charge			
	Ancillary Charges –			
59	– Physical Therapy			
60	– Occupational Therapy			
61	– Other Therapy			
62	– Patient Transportation			
63	– Programmatic Evaluation			
64	– Other Covered Ancillary			
65	Program Charge Allowances	( )		
66	Bad Debts	( )		
67	Other Revenue Deduction	( )		
68	Total Revenue – Covered Services			
69	NF Revenue From Ancillary Services Not Covered by LTC Program			
70	Total NF Revenue			
	Lines 71-84 not used			

Schedule B
Revenue and Costs

PART 1: Patient Revenues

Other Than LTC Patient Revenues

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
	Revenue From Patient Services:			
85	Room, Board			
86	Other Routine Charge			
	Ancillary Charges –			
87	– Physical Therapy			
88	– Occupational Therapy			
89	– Other Therapy			
90	– Patient Transportation			
91	– Programmatic Evaluation			
92	– Other Covered Ancillary			
93	Charity and Courtesy Allowances	( )		
94	Bad Debts	( )		
95	Other Revenue Deduction	( )		
96	Total Revenue – Covered Services			
97	Patient Revenue From Ancillary Services Not Covered by LTC Program			
	Other Patient Revenue Accounts:			
98				
99				
100				
101				
102				
103				
104				
105				
106				
107				
108				
109				
110				
111	Total patient revenue other than LTC			
112	Total patient revenue part 1			

Schedule B
Revenue and Costs
PART 2: Other Revenue

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
1	Gifts and Grants, Restricted – Fixed Asset			
2	Gifts and Grants Restricted – Other			
3	Gifts and Grants, Unrestricted			
4	Investment Revenue – Operating Funds			
5	Invest. Revenue – Bond Reserve Fund			
6	Invest. Revenue – Gifts and Grants Fund			
7	Interest From Late Charges			
8	Meals Sold to Employees and Guests			
9	Meals on Wheels			
10	Telephone Charges			
11	Personal Purchases Reimbursements			
12	Sale of Supplies			
13	Rental of Non-Patient Fac. and Equip.			
14	Purchase Discounts			
15	Rebates + Returns			
16	Vending			
17	Outpatient Revenue			

Schedule B
Revenue and Costs
PART 2: Other Revenue

Line No.	A Category/Account Description	B Facility Trial Balance	C Amount to Offset Cost	D Part 3 Line No. To Offset
18	Barber/Beauty Shop Revenue			
19	Interest on Funded Depreciation			
	Other Accounts:			
20	Not Intergovernmental Transfer			
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47	Total Other Revenue - Part 2			

Schedule B
Revenue and Costs

PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Administration:								
1	Salary and Wages – Administrator								1
2	Other Compensation – Administrator								2
	Salary, Wages, and other Compensation								
3	– Assistant Administrator								3
4	– Other								4
5	Payroll Taxes								5
6	Employee Benefits								6
7	Management Fees/Central Office Admin.								7
8	Legal and Accounting Services								8
9	Board Fees					3			9
10	Board Meeting Costs								10
11	Office Supplies								11
12	Printing and Postage/Newsletter								12
13	Total Telephone Cost								13
14	Professional Liability Insurance								14
15	Licenses								15
16	Association Dues								16
17	Education and Training								17
18	Travel								18
19	Advertising					3			19
20	Donations					3			20
21	Fund Raising Cost								21
22	Life Insurance on Officers and Owners								22
23	Short Term Equipment Rental								23
24	Group Buying Service Cost								24
25	Other Costs – Reimbursable:								25
26									26
27									27
28									28
29									29
30									30
31									31
32	Other Costs – Not Reimbursable					3			32
33	Revenue Offsets Not Identified to a Specific Account								33
34	Total Administration Cost								34

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	General:								
35	Payroll Taxes – FICA			0	0	0			35
36	Other Payroll Taxes			0	0	0			36
	Employee Benefits –								
37	– Worker Compensation Insurance			0	0	0			37
38	– Health Insurance			0	0	0			38
39	– Life Insurance			0	0	0			39
40	– Retirement			0	0	0			40
41	– Other Employee Benefits - Reimbursable			0	0	0			41
42				0	0	0			42
43				0	0	0			43
44	– Employee Benefits - Not Reimbursable					3			44
45	Total General Cost								45
	Dietary:								
	Salary, Wages and Other Compensation								
46	– Dietician								46
47	– Cooks								47
48	– Other								48
49	Payroll Taxes								49
50	Employee Benefits								50
51	Consultant – Dietician								51
52	Other Purchased Services								52
53	Food								53
54	Supplies								54
55	Education and Training								55
56	Travel								56
57	Short Term Equipment rental								57
58	Other Costs – Reimbursable								58
59									59
60									60
61	Other Costs – Not Reimbursable					3			61
62	Revenue Offsets Not Identified to a Specific Account								62
63	Total Dietary Cost								63

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Housekeeping:								
64	Salaries, Wages and other Compensation								64
65	Payroll Taxes								65
66	Employee Benefits								66
67	Purchased Services								67
68	Education and Training								68
69	Travel								69
70	Supplies								70
71	Short Term Equipment Rental								71
72	Other Costs – Reimbursable:								72
73									73
74									74
75									75
76	Other Costs – Not Reimbursable					3			76
77	Revenue Offsets Not Identifiable to a Specific Account								77
78	Total Housekeeping Cost								78
	Laundry:								
79	Salaries, Wages and Other Compensation								79
80	Payroll Taxes								80
81	Employee Benefits								81
82	Purchased Services								82
83	Education and Training								83
84	Travel								84
85	Linens								85
86	Supplies								86
87	Short Term Equipment Rental								87
88	Other Costs – Reimbursable:								88
89									89
90									90
91	Other Costs – Not Reimbursable					3			91
92	Revenue Offsets Not Identifiable to a Specific Account								92
93	Total Laundry Cost								93

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Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Nursing Services:								
94	Salaries, Wages and Other Compensation								94
95	– Director of Nursing								95
96	– Registered Nurses								96
97	– Practical Nurses								97
98	– Care Staff and Aides								98
99	– Medical Records								99
100	– Other Direct Care Nursing								100
101	Payroll Taxes								101
102	Employee Benefits								102
103	Consulting Registered Nurse								103
104	Purchased Services – Direct Care								104
105	Other Consulting Services (i.e. P.T., Pharm.)								105
106	Education and Training								106
107	Travel								107
108	Dues and Subscriptions								108
109	Supplies								109
110	Routine Oxygen Supply								110
111	Short Term Equipment Rental								111
112	Other Costs – Reimbursable								112
113									113
114									114
115									115
116									116
117									117
118									118
119									119
120									120
121									121
122									122
123									123
124									124
125									125
126	Other Costs – Not Reimbursable:					3			126
127	Revenue Offsets Not Identifiable to a Specific Account								127
128	Total Nursing Cost								128

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Plant Related:								
129	Salaries, Wages and Other Compensation								129
130	Payroll Taxes								130
131	Employee Benefits								131
132	Contracted Services								132
133	Education and Training								133
134	Travel								134
135	Supplies								135
136	Vehicle Gasoline, Repairs and Maintenance								136
137	Other Equipment Repairs and Maintenance								137
138	Building Repairs and Maintenance								138
139	Natural Gas, Fuel, Oil and Propane								139
140	Electricity								140
141	Water and Sewage								141
142	Refuse Service								142
143	Cable Television Service								143
144	Insurance (i.e. Boiler, Building, Auto)								144
145	Short Term Equipment Rental								145
146	Other Costs – Reimbursable:								146
147									147
148									148
149									149
150									150
151									151
152									152
153									153
154									154
155									155
156									156
157									157
158									158
159									159
160									160
161	Other Costs – Not Reimbursable					3			161
162	Revenue Offsets Not Identifiable to a Specific Account								162
163	Total Plant Related Cost								163

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Activities and Social Services:								
	Salaries, Wages and Other Compensation –								
164	– Activities								164
165	– Social Services								165
166	Payroll Taxes								166
167	Employee Benefits								167
168	Purchased Services								168
169	Consultants								169
170	Education And Training								170
171	Travel								171
172	Activities Resident Transportation								172
173	Dues and Subscriptions								173
174	Supplies								174
175	Short Term Equipment Rental								175
176	Other Costs – Reimbursable:								176
177									177
178									178
179									179
180									180
181									181
182	Other Costs – Not Reimbursable					3			182
183	Revenue Offsets Not Identifiable to a Specific Account								183
184	Total Activities and Social Services Cost								184
185	Other Revenue Offsets to Operating Cost Not Specifically Identifiable to a Category								185
186	Total Operating Cost								186

Schedule B
Revenue and Costs

PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Physical Therapy:								
187	Salaries, Wages and Other Compensation					3			187
188	Payroll Taxes					3			188
189	Employee Benefits					3			189
190	Purchased Services					3			190
191	Short Term Equipment Rental					3			191
192	Other Costs – Reimbursable					3			192
193	Revenue Offsets Not Identifiable to a Specific Account					3			193
194	Total Physical Therapy Cost								194
	Occupational Therapy:								
195	Salaries, Wages and Other Compensation					3			195
196	Payroll Taxes					3			196
197	Employee Benefits					3			197
198	Purchased Services					3			198
199	Short Term Equipment Rental					3			199
200	Other Costs – Reimbursable					3			200
201	Revenue Offsets Not Identifiable to a Specific Account					3			201
202	Total Occupational Therapy Cost								202
	Respiratory Therapy:								
203	Salaries, Wages and Other Compensation								203
204	Payroll Taxes								204
205	Employee Benefits								205
206	Purchased Services								206
207	Short Term Equipment Rental								207
208	Other Costs – Reimbursable								208
209	Revenue Offsets Not Identifiable to a Specific Account								209
210	Total Other Reimbursable Therapy Cost								210

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Resident Transportation – Medical:								
211	Salaries, Wages and Other Compensation								211
212	Payroll Taxes								212
213	Employee Benefits								213
214	Purchased Services								214
215	Mileage Reimbursement								215
216	Short Term Equipment Rental								216
217	Other Costs – Reimbursable								217
218	Revenue Offsets Not Identifiable to a Specific Account								218
219	Total Resident Transportation								219
220	Total Programmatic Evaluations								220
221	Other Revenue Offsets Not Identifiable to a Specific Covered Ancillary Category								221
222	Total Covered Ancillary Cost								222
	Other Ancillary – Not Covered:								
223	Pharmacy – Salaries and Other					3			223
224	Drugs and Medications					3			224
225	Radiology – Salaries and Other					3			225
226	Physician Services – Salaries and Other					3			226
227	Dental Services – Salaries and Other					3			227
228	Other Practitioner Services – Salaries and Other					3			228
229	Oxygen Over 1 K Tank in 3 Days					3			229
230	Other Ancillary Services Not Covered					3			230
231	Total Ancillary Cost – Not Covered								231
232	Total Ancillary Cost								232

Schedule B
Revenue and Costs
PART 3: Costs and Allocations

Line No.	A Category/Account Description	B Facility Trial Balance	C Revenue Offsets	D Cost Report Adjustments	E Cost For Allocation	F Allocation Basis No.	G Allowable NF	H Unallowable and Other	Line No.
	Fixed Costs:								
233	Depreciation (complete Schedule D)								233
234	Interest (complete schedule E)								234
	Long-term Lease Cost (complete schedule F)								
235	– Building and Permanent Equipment Lease								235
236	– Vehicle Leases								236
237	– Other Long-term Equipment Leases								237
238	Real Estate Tax								238
239	Personal Property Tax								239
240	Amortization – Start-Up Cost								240
241	Amortization – Organization Cost								241
242	Amortization – Bond Expenses								242
243	(Gains) Losses on Personal Property								243
244	Other Fixed Cost – Reimbursable								244
245									245
246									246
247	Other Fixed Costs – Not Reimbursable					3			247
248	Revenue Offsets Not Identifiable to a Specific Account								248
249	Total Fixed Cost								249
Line No.	**Category/Account Description**	**Facility Trial Balance**	**Revenue Offsets**	**Cost Report Adjustments**	**Cost For Allocation**	**Allocation Basis No.**	**Allowable NF**	**Unallowable and Other**	**Line No.**
	Cost Centers – Not Reimbursable								
250	Direct Cost – Beauty and Barber Services					3			250
251	Direct Cost – Canteen/Cafeteria/Vending					3			251
252	Direct Cost – Apartments					3			252
253	Direct Cost – Residential Services					3			253
254	Direct Cost – Hospital Services					3			254
255	Other Cost Centers – Not Reimbursable					3			255
256						3			256
257						3			257
258	Total Cost Centers – Not Reimbursable								258
259	Quality Assurance Assessment		Informational purposes only - provider tax is reimbursed according to 471 NAC 12-011.08D4.						259

Schedule B

Revenues and Costs

Part 4: Revenues and Cost Summary

Line No.	A Category	B Amount	
	Revenues		
1	Total Patient Revenue		Schedule B, Part 1, Column B, Line 112
2	Total Other Revenue		Schedule B, Part 2, Column B, Line 47
3	Total Revenue		
	Costs		
4	Administration		Schedule B, Part 3, Column B, Line 34
5	General		Schedule B, Part 3, Column B, Line 45
6	Dietary		Schedule B, Part 3, Column B, Line 63
7	Housekeeping		Schedule B, Part 3, Column B, Line 78
8	Laundry		Schedule B, Part 3, Column B, Line 93
9	Nursing		Schedule B, Part 3, Column B, Line 128
10	Plant		Schedule B, Part 3, Column B, Line 163
11	Activities and Social Services		Schedule B, Part 3, Column B, Line 184
12	Total Operating Cost		Schedule B, Part 3, Column B, Line 186
13	Total Ancillary Cost		Schedule B, Part 3, Column B, Line 232
14	Total Fixed Cost		Schedule B, Part 3, Column B, Line 249
15	Total Cost Centers – Not Reimbursable		Schedule B, Part 3, Column B, Line 258
16	Quality Assurance Assessment		Schedule B, Part 3, Column B, Line 259
17	Total Costs		
	Income		
18	Net Income Before Tax		
19	Income Tax Provision		
20	Net Income After Tax		

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Schedule B-1

General Cost Allocation and Adjustment

Line No.	A	B	FICA Allocation						Other Payroll Tax						Fringe Benefits			
	Payroll Category	Salaries, Wages, Other Comp Reported	C Exemption	D Allocation Basis	E Percentage	F Adjustment Inc/(Dec)	G Line No. Adjust	H Exemption	I Allocation Basis	J Percentage	K Adjustment Inc/(Dec)	L Line No. Adjust	M Percentage	N Adjustment Inc/(Dec)	O Line No. Adjust
1	Administrator						5					5			6
2	Assistant Administrator						5					5			6
3	Other Admin. Personnel						5					5			6
4	Dietician						49					49			50
5	Cooks						49					49			50
6	Other Dietary Personnel						49					49			50
7	Housekeeping						65					65			66
8	Laundry						80					80			81
9	Director of Nursing						100					100			101
10	Registered Nurses						100					100			101
11	Practical Nurses						100					100			101
12	Care Staff and Aides						100					100			101
13	Medical Records						100					100			101
14	Other Direct Care Nursing						100					100			101
15	Plant Related						130					130			131
16	Activities						166					166			167
17	Social Services						166					166			167
18	Physical Therapy						188					188			189
19	Occupational Therapy						196					196			197
20	Other Therapy						204					204			205
21	Resident Transportation						212					212			213
22	Other Ancillary Personnel						230					230			230
23	Other Cost Ctrs. Personnel						255					255			255
24	Total				100.00%	Total Reduces Sched. B, Part 3, Line No. 35 to 0				100.00%	Total Reduces Sched. B, Part 3, Line No. 36 to 0		100.00%	Total Reduces Sched. B, Part 3, Line No. 37-43 to 0	

Schedule B-2
Transactions with Related Organizations - Report and Adjustments

This part must be completed if any costs reported on Schedule B, Part 3 other than Leases, Interest or Depreciation, include transactions with related organizations.
For related organization: Leases, complete Schedule F; Interest, complete Schedule E and Depreciation, complete Schedule D.

	A	B	C	D	E	F	G	H	I
	Name of Related Organization or Individual	Percent of Ownership: Related Organization in Nursing Home	Percent of Ownership: Nursing Home in Related Organization	Common Owners: Percent Ownership in Nursing Home	Common Owners: Percent Ownership in Related Firm	Purchases from Related Organization in the Amount of	* Cost to Related Organ. of Services/ Items Purchased	Amount to (Increase) Amount to Decrease Cost (Col. F – G)	Schedule B Line #
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									

*** If the related organization qualifies for exception to the limitation write "Exception" in Column G and enter 0 in Column H.**

Use copies of this page if additional lines are needed.
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Schedule B-3

Compensation of Owners, Directors and Other Related Parties - Report and Adjustments

This part must be completed if any costs reported on Schedule B, Part 3 include salaries, wages or other compensation paid to owners, officers or persons related to an officer or owner. Attach specific job description for each position listed.

	A	B	C	D	E	F	G	H	I
	Name of Individual	Position (Attach Job Description)	Documented Percentage of 40 Hours Wks.	Relation. and Percentage Owned	Amount	Amount Per Trial Balance	Amount Allowable	Amount to Decrease	Schedule B Line Number
1					a. Salary, Wages, and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
2					a. Salary, Wages, and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
3					a. Salary, Wages, and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
4					a. Salary, Wages, and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				
5					a. Salary, Wages, and Other Compensation				
					b. Payroll Taxes				
					c. Fringe Benefits				
					d.				
					e.				

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Schedule B-4
Other Cost Adjustments

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
1	Fund Raising Cost:			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
	d. Other			
2	Private Duty Nurses and Aides			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
3	Unallowable Payroll:			
	a. Salaries			
	b. Payroll Taxes			
	c. Fringe Benefits			
4	Fees Paid Board of Directors			
5	Unallowable Management Fees			
6	Yellow Pages Display Advertisement in Excess of an Alpha Listing or Outside Immediate Service Area			
7	Other Promotional Advertising, (TV, Radio, Publications, etc.)			
8	Membership Dues and Costs (Social and Fraternal Organizations)			
9	Travel and Entertainment: Other Than For Professional Meetings and Direct Operations of the Home			
10	Donations			
11	Non-Reimbursed Use of Facility's Vehicles/Equipment for Non-Facility Purpose			

Schedule B-4
Other Cost Adjustments

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Line No. to Adjust
12	Life Insurance Premiums on Owners and Officers			
13	Political Contributions (Includes PAC's)			
14	Drugs Not Identified on Schedule B Part 3, Line 224			
15	Resident Luxury Items (Personal Phones, etc.)			
16	Fines and Penalties			
17	Real Estate and Property Taxes Not Related to Patient Care			
18	Interest on Loans Exceeding 80% of Fixed Asset Cost From Schedule E, Part 2			
19	Related Party Interest Cost From Schedule E, Part 1			
20	Non-Nursing Home Operations Interest Cost From Schedule E, Part 1			
21	Depreciation Adjustment From Schedule D, Part 1			
22	Lease Costs Limited to Owners Cost			
	(Sch. F, Part 1) a. Bldg. & Perm Equip			
	b. Vehicle			
	c. Other Long-term			
23	Actual Cost of Ownership (Leases)			
	(From Sch. F Part 1) a. Depreciation			
	b. Interest			
	c. Other			
	d.			

Schedule B-4
Other Cost Adjustments

	A	B	C	D
	Adjustment Description	Amount to Increase Cost	Amount to Decrease Cost	Line # to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

Schedule B-4
Other Cost Adjustments

	A	B	C	D
	Adjustment Description	Amount to Increase Cost	Amount to Decrease Cost	Line # to Adjust
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

This schedule is to be used only for adjustments to Schedule B, Part 3.

Similar schedules are included for other adjustments to other report schedules.

Use copies of this page if additional lines are needed.
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Schedule B-5
Statistical Data for Allocations

NOTE: Round percentage to two digits after the decimal. Example: round 53.7683% to 53.77%

A	B	C	NF	D
Basis No.	Allocation Basis	Total		Other
0	Actual Costs are Identified	100.00%	100.00%	100.00%
1	Entire Account is NF			
2	Not Used			
3	Entire Amount is Not Reimbursed	100.00%	0.00%	100.00%
4	Inpatient Days			
	Percent of Total	100.00%	. %	. %
5	Licensed Beds			
	Percent of Total	100.00%	. %	. %
6	Meals Served			
	Percent of Total	100.00%	. %	. %
7	Laundry Pounds			
	Percent of Total	100.00%	. %	. %
8	Square Feet			
	Percent of Total	100.00%	. %	. %
9	Accumulated Cost Except Adm.			
	Percent of Total	100.00%	. %	. %
10				
	Percent of Total	100.00%	. %	. %
11				
	Percent of Total	100.00%	. %	. %
12				
	Percent of Total	100.00%	. %	. %
13				
	Percent of Total	100.00%	. %	. %
14				
	Percent of Total	100.00%	. %	. %
15				
	Percent of Total	100.00%	. %	. %
16				
	Percent of Total	100.00%	. %	. %

Schedule B-5
Statistical Data for Allocations

A	B	C	NF	D
Basis No.	Allocation Basis	Total		Other
17				
	Percent of Total	100.00%	. %	. %
18				
	Percent of Total	100.00%	. %	. %
19				
	Percent of Total	100.00%	. %	. %
20				
	Percent of Total	100.00%	. %	. %
21				
	Percent of Total	100.00%	. %	. %
22				
	Percent of Total	100.00%	. %	. %
23				
	Percent of Total	100.00%	. %	. %
24				
	Percent of Total	100.00%	. %	. %
25				
	Percent of Total	100.00%	. %	. %
26				
	Percent of Total	100.00%	. %	. %
27				
	Percent of Total	100.00%	. %	. %
28				
	Percent of Total	100.00%	. %	. %
29				
	Percent of Total	100.00%	. %	. %
30				
	Percent of Total	100.00%	. %	. %
31				
	Percent of Total	100.00%	. %	. %

Schedule C
Comparative Balance Sheet

	A Assets	B Previous Year Ending	C Current Year Ending
	Current Assets		
1	Cash on Hand		
2	Checking Account		
3	Savings Account		
4	Accounts Receivable – Private		
5	Accounts Receivable - Medicaid		
6	Accounts Receivable – Other		
7	Inventories		
8	Prepaid Expenses		
9	Loans to Related Parties		
10	Short Term Investments		
11	Other:		
12			
	Long-term Assets		
13	Land		
14	Land Improvements		
15	Accumulated Depreciation Land Improvements		
16	Building and Additions		
17	Accumulated Depreciation Bldg. & Additions		
18	Furniture and Equipment		
19	Accumulated Depreciation Furniture & Equip.		
20	Vehicles		
21	Accumulated Depreciation Vehicles		
22	Leasehold Improvements and Additions		
23	Accumulated Depreciation Leasehold Imp. & Add.		
24	Start-Up, Organization and Bond Costs		
25	Accumulated. Amort. Start-Up, Organiz. & Bond Cost		
26	Other		
27	Accumulated Depreciation Other		
28	Funded Depreciation		
29	Bond Sinking Fund		
30	Long-term Investments		
	Intangibles		
31	Goodwill		
32	Other:		
33			
34	Total Assets		

Schedule C
Comparative Balance Sheet

	A Liabilities and Equity	B Previous Year Ending	C Current Year Ending
	Current Liabilities		
35	Salaries and Wages Payable		
36	Payroll Taxes Payable		
37	Real Estate and Property Taxes Payable		
38	Income Tax Payable		
39	Loans From Related Parties		
40	Current Portion of Long-term Debt		
41	Short Term Notes Payable		
42	Accounts Payable		
43	Other:		
	Long-term Liabilities		
44	Mortgage Payable		
45	Bonds Payable		
46	Notes Payable		
47	Loans From Related Parties		
48	Other:		
49	Total Liabilities		
	Equity		
	Corporation:		
50	Capital Stock		
51	Paid in Capital		
52	Retained Earnings		
53			
54	Non-Profit Organization Equity		
55			
	Partnership and Proprietorship:		
56	Partner/Proprietary Capital Account		
57	Partner/Proprietary Drawing Account		
58			
	Other Equity Accounts:		
59	Intercompany Account		
60	Other:		
61			
62	Total Equity		
63	Total Liabilities and Equity		

Schedule D
Depreciation Cost

PART 1: Depreciation Schedule Summary

Line No.	A Description of Property	B Date Acquired	C Trial Balance	D Cost Adjustments	E Cost Long-term Care Value	F Salvage Value	G Depreciation Method Required	H Useful Life	J Prior Years Depreciation	K Depreciation Cost	L Medicaid Book Value
1	Land										
2	Land Improvements						SL				
3							SL				
4							SL				
5	Main Buildings						SL				
6	Building Additions						SL				
7							SL				
8							SL				
9	Original Furniture						SL				
10	Furniture Additions						SL				
11							SL				
12							SL				
13	Original Equipment						SL				
14	Equipment Additions						SL				
15							SL				
16							SL				
17	Vehicles						SL				
18							SL				
19							SL				
20	Leasehold Improvements						SL				
21	Leasehold Additions						SL				
22							SL				
23							SL				
24	Other:						SL				
25							SL				
26							SL				
27	Lessor's Cost (From Sch. E)										
28	Totals										
29	Depreciation from Trial Balance (Schedule B, Part 3, Column B, Line 233)										
30	Depreciation Adjustment to Long-term Care Allowable Cost (Line 28 minus Line 29)										

Enter on Schedule B-4 Line 21

Schedule D
Depreciation Cost

PART 2: Current Report Period Additions

A	B		D	E	F	G	H		J
Specific Item Description	Date Acquired		Useful Life	Depreciation Method Required	Original Cost	Salvage Value	Current Year Depreciation Cost		Schedule D Part 1 Line No.
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					

PART 3: Current Report Period Deletions

A	B	C	D	E	F	G	H	I	J
Specific Item Description	Date Acquired	Date of Disposal	Useful Life	Depreciation Method Required	Original Cost	Salvage Value	Current Year Depreciation Cost	Accumulated Depreciation	Schedule D Part 1 Line No.
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					
				SL					

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Schedule D-1
Depreciation Schedule Adjustments

	A Adjustment Description	B Amount to Increase Cost	C Amount to Decrease Cost	D Sched. D Line No. to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

This schedule is to be used only for adjustments to Schedule D, Part 1.

Similar schedules are included for other adjustments to other report schedules.

Use copies of this page if additional lines are needed.
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Schedule E
Interest Cost

PART 1: Loans and Interest Cost Summary

This part of Schedule E must be completed if any interest cost is included on Schedule B, Part 3.
Attach one copy of the signed loan agreement for all loans originated or refinanced during the report period.

	A	B	C	D	E	F	G	H	J	K	L
	Source			Variable		Ending Loan Balance				Interest Cost	
	Security and Purpose	Related Party (X) / Date of Origin / Date Mature	Original Loan Amount	Interest Rate	Adjusted Beginning Loan Balance	Trial Balance	Adjustments	Adjusted Ending	Paid to Unrelated Parties	Paid to Related Parties	Non-Nursing Facility Operations
1											
2											
3											
4											
5											
6											
7											
8											
9											
10	Lessor's Cost (Schedule F)										
11	Grand Total									Enter on Schedule B-4 Line 19	Enter on Schedule B-4 Line 20
12	Total Related Parties										
13	Total Non-Nursing Home										
14	Total Unrelated Parties										

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Schedule E
Interest Cost

PART 2: Interest Limitation Computation

Either Option 1 or Option 2 may be used to compute the limitation. If Option 2 is used all subsequent reports must also use Option 2.

OPTION 1: Annual Average

1	Ending Loan Balance Unrelated Parties			7	Beginning Loan Balance – Unrelated Parties		
	Schedule E, Part 1, Column H, Line 14				Schedule E, Part 1, Column E, Line 14		
2	Total Balance Asset Cost			8	Ending Loan Balance – Unrelated Parties		
	Schedule D, Part 1, Column C, Line 28				Schedule E, Part 1, Column H, Line 14		
	Asset Cost Adjustments				Average Loan Balance – Unrelated Parties		
3	Schedule D, Part 1, Column D, Line 28			9	Divide the Total of Line 7 Plus Line 8 by 2		
	Net Allowable Asset Cost – Long-term Care Value				Interest Paid to Unrelated Parties		
4	Line 2 Plus Line 3; Schedule D, Part 1, Column E, Line 28			10	Schedule E, Part 1, Column J, Line 11		
					Average Interest Rate		
5	80% of Fixed Asset Cost - Line 4 Times 0.80			11	Line 10 Divided by Line 9		
6	Difference - Line 1 Minus Line 5				Interest Limitation Line 6 Times Line 11		
If Line 6 is 0 or negative amount, skip to line 12 and enter 0.				12	(Enter on Schedule B-4, Line 18)		

OPTION 2: Monthly Average

	A	B	C	D	E	F	G	H	I	J
	Date (1)	Total All Interest Bearing Loans	Total Related Party Interest Bearing Loans	Total Non-Nursing Home Loans	Allowable Loan Balance (Col B - Col C - Col D)	Cost of Fixed Assets Related To Care (2)	80% of Asset Cost (80% of Col. F)	Loan Bal. Over 80% of Asset Cost Col. E – Col. G	Average Interest Rate	Interest Adjust. (Col. H x Col I ÷ by No. of Months)
1	July 1									
2	July 31									
3	August 31									
4	September 30									
5	October 31									
6	November 30									
7	December 31									
8	January 31									
9	February 28/29									
10	March 31									
11	April 30									
12	May 31									
13	June 30									
14	Totals									
15	Monthly Average							Interest – Unrelated Parties		Enter on Sch B-4, Line 18)
						16	Schedule E, Part 1, Column J, Line 11			
	(1) Any Loan acquired and paid during the same month must be included on the last day of the month					17	Average Loan Balance – Unrelated Parties Schedule E, Line 15			
	(2) Cost of fixed assets must be the monthly, net allowable asset cost amounts, similar to the year end amount on Schedule D, Part 1, Column E, Line 28. Worksheets must be available at the facility to support the amounts reported					18	Average Interest Rate Line 16 ÷ 17 Use for all Lines of Column I			

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Schedule E-1
Loan Schedule Adjustments

	A Adjustment Description	B Increase of Loan Amount	C Decrease of Loan Amount	D Sched. E, Part 1 to Adjust
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

This schedule is to be used only for adjustments to Schedule E, Part 1.

Similar schedules are included for other adjustments to other report schedules.

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Schedule F
Leases

PART 1: Leases and Lease Adjustments

1	Assigned Lease Number	Number:	Number:	Number:	Number or Total:	
2	Leasing Company or Individual					If any lease was originated, renegotiated, or otherwise changed during the report period, include ONE copy with the submitted report.
3	Items Leased					
4	Cost Included on Trial Balance					
5	Check Line That Applies:					Record the totals in the last column of the last page.
	a) Related Organization					
	b) Facility Leased after 7/31/82					
	c) Lease Purch. (Per HIM-15, Sect 110.b)					
	d) Sale and Lease Back					
	e) Other					
	For each lease checked on line 5a, 5b, 5c, or 5d, complete a Part 2 and complete Lines 6 thru 18 according to instructions on Part 2. For each lease checked on line 5e do not complete Part 2 or Lines 6 thru 18.					
	Cost to Reduce:					Transfer Totals to:
6	Building and Perm. Equip. Lease					Schedule B-4, Lines 22
7	Vehicle Lease					
8	Other Long-term Lease					
	Cost to Allow:					
9	Depreciation					Schedule B-4, Line 23a
10	Interest					Schedule B-4, Line 23b and Schedule E, Part 1, Col. J, Line 10
11	Other:					Schedule B-4, Line 23c and d (and additional lines 1 to 20 as needed)
12						
13						
14						
15						
	Other Ownership Data:					
16	Asset Cost					Schedule D, Part 1, Col. E, Line 27
17	Beginning Loan Balance					Schedule E, Part 1, Col. E, Line 10
18	Ending Loan Balance					Schedule E, Part 1, Col. H, Line 10

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Schedule F
Leases

Part 2

A separate Part 2 must be completed for each Lease on Part 1 checked on Line 5a, 5b, 5c, or 5d. Do not complete if Line 5e is checked on Part 1.

1. Lease No. Assigned From Part 1 No.:	2. Total Lease Cost	If Line 5a is checked on Part 1, complete items 4, 5, and 6 based on related owner's actual costs and transfer totals to Part 1.	If Line 5b is checked on Part 1, complete item 3, complete items 4, 5, and 6 based on owner's cost.	If Line 5c is checked on Part 1, complete items 4, 5, and 6 based on amounts as if leased items were purchased.	If Line 5d is checked on Part 1, complete items 4, 5, 6, based on amounts had title not been transferred.

3. Complete this item if Line 5b is checked on Part 1.
   a. Does the lease require the owner to provide a statement of ownership costs for each report period?
   ☐ Yes ☐ No
   b. Does the lease require the owner to make records available for audit by the Nebraska Department of Health and Human Services, the U.S. Department of Health and Human Services or their designated representatives?
   ☐ Yes ☐ No
   c. Was a statement of costs provided by the owner for this report period?
   ☐ Yes ☐ No

If total owner's cost is less than the lease cost transfer amount to Part 1 – OR If owner's cost is more than the lease cost DO NOT transfer the amounts to Part 1.

If total owner's cost is less than the lease cost transfer amounts to Part 1 – OR If owner's cost is more than the lease cost DO NOT transfer the amounts to Part 1.

Transfer totals to Part 1.

If any of the above are no, enter 0 for items 4, 5 and 6

4. Depreciation Schedule – Only leased assets used in Long-term Care. Include only allowable amounts.

Property Descriptions	Date Acquired	Asset Cost	Salvage Value	Useful Life	Depreciation	Accumulated Depreciation
Totals						

5. Loans and interest – Only include loans related to the leased assets used in providing Long-term Care Services. Include only allowable amounts.

6. Other Costs related to leased items used in LTC Svs. Incl. only allowable amounts

Source/Security	Date of Origin/ Maturity	Original Amount	Rate	Beginning Balance	Ending Balance	Interest	Total	Category/ Account	Amount
Totals									

Preparer Acknowledgement

The Nebraska Department of Health and Human Services expects any individual or organization preparing the Long-Term Care Cost Report to have or obtain knowledge of the accounting principles and practices of the long-term care industry and the reporting requirements and regulations governing the Nebraska Medical Assistance Program for long-term care reimbursement; to discuss regulatory limitations and unallowable cost items with the provider's management; and to issue a report including disclosure of all known variances from the reporting requirements and regulatory requirements of the Nebraska Department of Health and Human Services.

I/we acknowledge that I/we read the above statement and, accordingly, prepared the accompanying Long-term Care Cost Report for _____ (Provider Name)
_____ (Provider Number) and issued the appropriate report on the preparation of the cost report.

SEE ATTACHED _____ REPORT.

Signature	Firm	Date

Certification of Officer, Owner, or Administrator

The long-term care provider participating in the Medicaid Long-term Care Program is responsible for accurate preparation of the Cost Report. Engagement of a certified public accountant or firm of certified public accountants to complete the report does not relieve that responsibility. The provider must inform the individual or firm engaged of all unallowable items included in the financial statements and other items, which otherwise unidentified, will result in securing Medicaid reimbursement over or under the amount permissible by the regulations of the Nebraska Medical Assistance Program.

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THE COST REPORT MAY BE PUNISHABLE BY CIVIL AND/OR CRIMINAL PENALTY, FINE OR IMPRISONMENT UNDER STATE OR FEDERAL LAWS.

I certify that I read the above statements and that I examined the accompanying cost report and supporting schedules prepared for _____ (Provider Name)
_____ (Provider Number) for the cost report period beginning _____ and ending _____

To the best of my knowledge and belief, the cost report is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions. All salary and non-salary costs presented in the report as a basis for securing reimbursement for Medicaid clients were incurred by the provider to deliver patient care. I also understand that all information in this report and all attachments may be subject to reviews and/or audits by the Nebraska Department of Health and Human Services, the U.S. Department of Health and Human Services or their designated representatives. All books, records and supporting documentation related to the information reported will be available for reviews and/or audits for the time period required by the Nebraska Department of Health and Human Services.

Signature	Title	Date