FYE 2025

GENERAL INSTRUCTIONS TO COST REPORT

FREESTANDING AND CHAIN COMPONENT NURSING FACILITIES

All financial information included in the cost report must be prepared in accordance with generally accepted accounting principles (GAAP); however, where the Centers for Medicare and Medicaid Services Manual (CMS-15) differs from GAAP, CMS-15 will prevail. The cost report must be filed using the accrual basis of accounting covering the accounting period from July 1, 2024 to June 30, 2025. All amounts should be reflected as whole dollars (unless otherwise indicated). Any changes in accounting procedures from the previous year should be detailed on a separate sheet, with an explanation of the changes and submitted with the current cost report.

Note that those facilities filing Medicare Cost Reports that are being allocated common costs of a hospital or other facility through the Medicare cost finding (Worksheet B) must file the cost report for hospital based providers in lieu of the freestanding nursing home cost report. Only those facilities that qualify as a hospital based facility will be grouped as such. (See Section 1002.1g of the Policies and Procedures for Nursing Facility Services manual.)

A copy of the complete electronic cost report and questionnaire must be emailed to the Department by September 30, 2025. The Policies and Procedures for Nursing Facility Services manual indicates that if the cost report is not emailed by September 30, 2025, the Department shall have the option of either terminating the provider agreement upon thirty (30) days written notice or imposing a penalty of $50 per day for the first thirty (30) days and a penalty of $100 per day for each day thereafter until an acceptable cost report is received by the Department. The only condition in which this penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services for the Department of Community Health prior to the September 30 deadline. Since incomplete reports are subject to the same penalty as late filings, all facilities are encouraged to file by September 1, 2025 to ensure no penalty is imposed. Copies of the various supporting documents required by certain schedules should be attached to both copies of the cost report. The supporting documents should be clearly labeled as to the schedule to which they refer.

A cost report must be prepared by each owner of a nursing facility if the facility was sold during the current period. Each owner should complete the cost report covering the period of their ownership of the nursing facility.

All cost reports should be emailed as an attachment to nhcostreport@dch.ga.gov.

We encourage a careful review of all the instructions before starting to prepare the cost report. Any costs which have been disallowed by the Department in prior years and not reversed upon appeal, should be excluded in this cost report. (Use Schedule B-4.) Please refer to the Social Security Act, Title XIX, Section 1909 and Title XI, Section 1128A for an outline of conditions leading to possible criminal and civil prosecution for providers who insist on including unallowable costs on cost reports.

Please code the county number using the following list:

Code	Code	Code	Code	Code
001. Appling	033. Cobb	065. Grady	097. McDuffie	129. Sumter
002. Atkinson	034. Coffee	066. Greene	098. McIntosh	130. Talbot
003. Bacon	035. Colquitt	067. Gwinnett	099. Meriwether	131. Taliaferro
004. Baker	036. Columbia	068. Habersham	100. Miller	132. Tattnall
005. Baldwin	037. Cook	069. Hall	101. Mitchell	133. Taylor
006. Banks	038. Coweta	070. Hancock	102. Monroe	134. Telfair
007. Barrow	039. Crawford	071. Haralson	103. Montgomery	135. Terrell
008. Bartow	040. Crisp	072. Harris	104. Morgan	136. Thomas
009. Ben Hill	041. Dade	073. Hart	105. Murray	137. Tift
010. Berrien	042. Dawson	074. Heard	106. Muscogee	138. Toombs
011. Bibb	043. Decatur	075. Henry	107. Newton	139. Towns
012. Bleckley	044. DeKalb	076. Houston	108. Oconee	140. Treutlen
013. Brantley	045. Dodge	077. Irwin	109. Oglethorpe	141. Troup
014. Brooks	046. Dooly	078. Jackson	110. Paulding	142. Turner
015. Bryan	047. Dougherty	079. Jasper	111. Peach	143. Twiggs
016. Bulloch	048. Douglas	080. Jeff Davis	112. Pickens	144. Union
017. Burke	049. Early	081. Jefferson	113. Pierce	145. Upson
018. Butts	050. Echols	082. Jenkins	114. Pike	146. Walker
019. Calhoun	051. Effingham	083. Johnson	115. Polk	147. Walton
020. Camden	052. Elbert	084. Jones	116. Pulaski	148. Ware
021. Candler	053. Emanuel	085. Lamar	117. Putnam	149. Warren
022. Carroll	054. Evans	086. Lanier	118. Quitman	150. Washington
023. Catoosa	055. Fannin	087. Laurens	119. Rabun	151. Wayne
024. Charlton	056. Fayette	088. Lee	120. Randolph	152. Webster
025. Chatham	057. Floyd	089. Liberty	121. Richmond	153. Wheeler
026. Chattahoochee	058. Forsyth	090. Lincoln	122. Rockdale	154. White
027. Chattooga	059. Franklin	091. Long	123. Schley	155. Whitfield
028. Cherokee	060. Fulton	092. Lowndes	124. Screven	156. Wilcox
029. Clarke	061. Gilmer	093. Lumpkin	125. Seminole	157. Wilkes
030. Clay	062. Glascock	094. Macon	126. Spalding	158. Wilkinson
031. Clayton	063. Glynn	095. Madison	127. Stephens	159. Worth
032. Clinch	064. Gordon	096. Marion	128. Stewart	

The Medicaid Cost Report can be prepared in a more efficient manner if a prescribed sequence is followed. A suggested sequence for the preparation process is provided:

1. Schedule A, statistical information can generally be prepared at any time.

2. Schedule B, B-1, B-2 and B-3 per books columns should be prepared first.

3. Schedules B-6, B-7, C, D, E, F, G, G-1, H and I should then be prepared. These schedules substantiate amounts reflected per books in Schedule B. Certain adjustments to allowable costs will surface, if applicable, as these schedules are prepared.

4. Schedules B-1A, B-4 and B-5 should then be completed which will finalize all adjustments to allowable costs.

5. All adjustments in Schedules B-1A, B-4 and B-5 should be entered, as appropriate, on Schedule B-2, the computation of "as adjusted" allowable costs by cost center made and the "as adjusted" totals entered on Schedule B.

6. A thorough final review should be made of the finalized cost report to verify it is complete, clerically accurate and cross-referenceable.

SCHEDULE CP - INSTRUCTIONS

Schedule CP is the certification required to be signed by the owner, corporate officer or administrator, as indicated on the schedule. Unsigned reports will not be accepted. The passcode issued by the Department must be entered to serve as the electronic signature. If you do not have a passcode, please send an email to nhpassword@dch.ga.gov to request a passcode for your facility. Further, a place is provided for the preparer of the cost report (if not an employee of the provider) to be identified. Where applicable, please provide the preparer's complete address and phone number.

SCHEDULE A

Part I – Inpatient Days: Total inpatient days by month are to be reported by form of payment (Medicare, Medicaid (FFS), Medicaid (CMO), or Private and Other) and by whether or not the patient is on-site or out on a leave/hospital stay (Hospital/Leave days for Medicaid recipients should only include those days reimbursable under the Medicaid Program). A patient day is the care of one patient during the period between the census-taking hour of two successive days. When a patient is admitted and discharged on the same day, this must be counted as one inpatient day. Column 1 should contain only Medicare recipient patient days. Column 2 should contain any Private pay and Other on-site patient days. Column 3 should contain any Private pay and Other Hospital/Leave patient days. Column 4 should contain any Medicaid (FFS) on-site patient days. Column 5 should contain any Medicaid (CMO) on-site patient days. Column 6 should contain any Medicaid Hospital/Leave days. Column 7 should be the total of columns 1, 2, 4 and 5. Column 8 should be totals of columns 3 and 6. Line 13, column 8 should also equal the sum of column 8, lines 1-12 for the applicable period. Please Note: Hospice days are considered private pay days. These days should be listed in column 2. See our Policies and Procedures manual for further information.

Part II – Bed Capacity: Total beds, as certified by the Standards and Licensure Unit of the Department of Human Resources, are to be listed in the spaces provided. Temporary changes in bed availability because of alterations, painting, etc., do not affect bed capacity. Distinct part facilities must provide bed capacity information separately for NF.

Bed days available are determined by multiplying the number of days in the period times number of certified beds. Take into account increases or decreases in the number of beds available and the number of days elapsed since the increase or decrease. As an example, if the number of certified beds increased from 50 to 100 as of September 30 of the reporting period the calculation would be as follows:

50 beds for 92 days = 4,600 bed days available
100 beds for 273 days = 27,300 bed days available
365 days = 31,900 bed days available during the period

Part III – Percent Occupancy: The percent of occupancy should be computed for each category in which bed capacity information has been provided.

Part IV – Minimum per diem Semi-Private Rates as of Last Day of Reporting Period: The minimum per diem semi-private rates must include only those charges for services comparable to those included in the Medicaid patient rate. Refer to the Policies and Procedures manual for information on how the facility's customary charges to the general public for services provided under the Georgia Medical Assistance Program can affect its reimbursement rate.

Part V – Breakdown of Medicare Advantage Days: Total Medicare Advantage days by month, the applicable reimbursement rate and total revenue are to be reported. These patient days should not be deducted from the patient days reported in Part I.

SCHEDULE B, B-1, B-2 AND B-3

Sub-schedules B-1, B-2 and B-3 provide the means to accumulate the information required for Schedule B. Specific cross-references to the pertinent sub-schedule are included in the Schedule B format. The per books amount reflected in Column 3 of Schedule B will require a combination of amounts from the applicable periods of the two fiscal years, if the provider's year end is other than June 30. Note that all per books amounts (Column 1) of Schedule B-2 must be carried over to Column 3 net of adjustments, if any.

The basic format of the sub-schedules follow the standard chart of accounts detailed in the DCH Uniform Chart of Accounts manual. (Refer to the policies and procedures manual for further information.) As stated therein, all providers participating in the Medicaid Program must utilize the Standard Chart of Accounts. Note that the account numbers have been grouped to accumulate information by the cost centers per Schedule B.

SCHEDULE B-1

Routine Service Revenues (Lines 1-7) and Ancillary Revenues (Lines 8-21) are self-explanatory. Line 7 should be equal to Schedule B, Line 1 and Line 21, Column 1 should be equal to Schedule B, Line 2. Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (See CMS-15, Section 2206.1 for information on accrual of charges and Section 2204.1 for hospital-based physicians' charges.)

SCHEDULE B-1A

The purpose of this schedule is to calculate the ancillary expense adjustments necessary to properly determine the Medicaid program's portion of ancillary services provided. Please make sure that costs and charges are properly matched in the appropriate columns of Schedule B-1A.

Line 1: The sum of the individual line items from Schedule B-2, Column 1, for each particular ancillary service should be entered here. For example, the amount to report on Line 1 for Physical Therapy is the sum of the amounts reported on Schedule B-2, Column 1, Lines 36-40.a: If the amounts do not agree with Schedule B-2, submit a supplementary schedule reconciling the two amounts.

Line 2: Report the amount of any Schedule B-4 adjustments to Ancillary expenses for each particular type of ancillary service.

Line 3: This is the difference between Line 1 and Line 2. For the Therapy Room Overhead columns, these numbers should be the amounts calculated on Schedule B-5, line 12.a.

Line 4: Total charges from Schedule B-1, Column 1, for each particular ancillary service should be reported on this line. Total Charges for the Therapy Room Overhead columns should be the sum of the amounts entered for Physical, Speech and Occupational Therapy.

Line 5: This is Line 3 divided by Line 4. The result is the cost to charges ratio. Include at least 4 digits to the right of the decimal point.

Line 6: Report Medicaid charges for each particular ancillary service from Schedule B-1, Column 2, for each particular type of ancillary service. Medicaid Charges should be recorded for Medicare Part B billable ancillary services for Medicaid eligible residents who are not covered by Medicare Part B or Private Insurance. (Medicaid charges must be accurately tracked. Estimates are not allowable). Medicaid Charges for the Therapy Room Overhead columns should be the sum of the amounts entered for Physical, Speech and Occupational Therapy.

Line 7: Medicaid cost is calculated by multiplying Lines 5 and 6 for each particular type of ancillary service.

Line 8: Total patient days are originally reported on Schedule A, Column 8, Line 13. Total patient days (same number) should be reported for each type of ancillary service.

Line 9: Medicaid patient days are originally reported on Schedule A, Columns 4 and 5, Line 13. The number to report on Line 9 is the sum of Column 4 and 5, on Line 13. Total Medicaid patient days (the same number) should be reported for each type of ancillary service.

Line 10: Maximum allowable costs equal Medicaid cost (Line 7) times the ratio of total patient days to Medicaid patient days (Line 8 divided by Line 9).

Line 11: Compare the amounts on Lines 3 and 10. Enter the larger amount here.

Line 12: The amount of the Schedule B-4 adjustment is the difference between maximum allowable costs (Line 10) and the amount on Line 11. These amounts should be reported on Schedule B-4 and adjusted to allowable costs on Schedule B-2, Column 2.

SPECIAL NOTE: The costs of prescription drugs, non-emergency transportation and laboratory are not allowable under the Nursing Home Program. (See Chapter 900 of the Policies and Procedures for Nursing Facility Services manual.) Costs and revenues related to these should not be included on Schedule B-1A. The costs should be removed using line 5 of Schedule B-4.

SCHEDULE B-2

Refer to Schedule B-4 where adjustments to expenses are summarized by type of adjustment. Such adjustments are to be entered in the adjustment column of Schedule B-2 for the appropriate expense account to arrive at the "as adjusted" amounts. Also refer to Schedule B-5 where an allocation of operating expenses is made to non-patient care areas and therapy rooms, where applicable. The results of this allocation, if applicable, are entered in the "as adjusted" column of Schedule B-2 on the line designated for this adjustment. After all adjustments have been reflected, the "as adjusted" totals for all Schedule B-2 line items should be determined and the "as adjusted" total, by cost center, entered in Column 4 of Schedule B.

Total salaries and wages data, by operating expense cost center (Schedule B, Column 1), will be obtained from the salaries expense accounts in Schedule B-2. As an example, the Routine Service center salaries for nursing facilities would require the amount per Column 3 in Schedule B-2 for account number 600.10 to be listed in Column 1, Line 5 of Schedule B.

Report all costs incurred for nurse aide training and testing in the Nurse Aide Training & Testing Cost Summary found below the Administrative & General expenses. The amounts shown for costs may, or may not, be the same as revenue received. Do not report revenue received in this summary. Only actual verifiable costs should be reported here. These costs must meet the criteria established by DCH's Uniform Chart of Accounts. The total amount of this summary should be transferred to Line 129, Column 1 of Schedule B-2.

In addition, there will be a final audit settlement made after actual expenses incurred are reviewed against reimbursement received from DCH. Therefore, all nurse aide training costs incurred should be adjusted out of Schedule B-2, Line 129, Column 2 via a B-4 adjustment on Line 44.

SCHEDULE B-3

This schedule should be utilized only if applicable amounts specifically related to the NF facility have not been included in Schedules B-1 or B-2.

SCHEDULE B-4

(Refer to CMS-15, Chapter 21 and the policies and procedures manual for guidelines on principles of allowable costs).

All adjustments to expenses per books are summarized on this schedule with the exception of those reported on Schedule B-5. Line descriptions indicate the more common activities which affect allowable costs or result in costs incurred not applicable to patient care and thus require adjustment.

Adjustments which may be necessary include, but are not limited to, revenues which are considered recoveries of cost (sale of meals, purchase discounts or rebates of expenses, etc.) or direct expense adjustments not allowed by specific regulations (bad debts, excessive owner's compensation, etc.). Please include prior year audit adjustments which offset current year cost and beginning equity capital. The principles of reimbursement under Medicare will apply except for cost of items specifically excluded from the Georgia Medicaid Plan.

On June 6, 1990, the Board of Medical Assistance voted to disallow certain costs. Please refer to Chapter 1000 of the Policies and Procedures for Nursing Facility Services manual for specifics regarding these costs. Some of the non-allowable costs include lobbying expenses, membership in civic organizations, certain out-of-state travel, certain vehicle depreciation and air transportation. In addition, 50% of membership association dues, certain legal fees and various advertising costs are non-allowable.

Any of these costs included on the cost report should be adjusted out by a B-4 adjustment.

Column 1: The amounts entered on Schedule B-4, should be noted "A" where the facility can determine costs. Where costs are not determinable, the notation "B" should be entered to indicate that the amount received for the service is the basis for the adjustment.

Column 2: Each adjustment amount must be entered in the appropriate line item category. Where the amount received is used as the basis for adjustment, the amount of the adjustment will generally agree with the revenues reported on Schedule B-3, Part I.

Column 3: The Schedule B-2 line number cross-reference must be provided in Column 3 for each line item to indicate where the adjustment will be recorded in Schedule B-2. Certain adjustments resulting from cost allocations, or where amount received is used as a basis for the adjustment, etc. will be difficult to relate to a specific account number. A separate line item has been established in each cost center in Schedule B-2 to reflect such adjustments described as "Adjustments Not Related to Specific Accounts". Each adjustment should be entered in the adjustment column (Column 2) of Schedule B-2 on the line number designated.

Column 4: Any clarifying comment that will help substantiate the position taken should be included. If the space is not adequate, a statement should be attached as an exhibit to this schedule.

Any adjustments not computed through an existing support schedule in the cost report or determined by using the amount received per Schedule B-3, will require additional clarification through a supporting computation attached as an exhibit to this schedule.

SCHEDULE B-5

(Note that this schedule does not have to be prepared if there are no non-patient care areas or therapy rooms).

For purposes of completing Schedule B-5, non-patient care area is defined as: any area of the facility that is used for activities that are either not covered by the Medicaid program or that the provider receives compensation solely from a third party payer, such as Medicare.

The purpose of Schedule B-5 is to isolate indirect expenses included in patient care cost centers related to non-patient care and therapy activities. Non-patient care activity expenses are not allowable costs for Medicaid reimbursement purposes and should be removed from the patient care cost centers. Examples of non-patient care areas are included in Schedule B-5. The non-Medicaid utilization portion of indirect expenses related to therapy activities is calculated on Schedule B-1A, using the amounts calculated on Schedule B-5. These amounts should also be removed from the patient care cost centers.

Detailed instructions for the allocation of indirect expenses to non-patient care and therapy areas are as follows:

Line 1: Insert the total expenses, as adjusted, before allocation of indirect expenses for the cost centers from Schedule B-2. This amount will be used as the expense allocation basis in lines 2 through 13 below.

Lines 2-13: Certain common non-patient care areas have been listed. This list is not all inclusive and space has been provided (Lines 5-11) to list any such areas peculiar to a particular provider. Column 1 requires that the square feet of each non-patient care area and the patient care (in total) be listed so as to compute each area's percentage (%) relationship to the total. For the purposes of completing Schedule B-5, please note that buildings not connected to the nursing facility that are used for patient care related activities may be included as long as they meet all of the following criteria: the building must be fully enclosed, heated or cooled, constructed of similar material as the nursing facility and be located on the same campus as the nursing facility. If a provider maintains a beauty and barber shop within the facility, the square footage should be included on Schedule B-5 if both of the following criteria are met: if the provider receives revenue (i.e. rent, commissions, etc.) from the beauty shop and if the space is not available for use by patients or their families when the beauty shop is not operating. The measurements for non-patient care areas reported on Schedule B-5 should match the measurements from the provider's most recent field exam. In the event of a change in physical space and/or the utilization, the provider should provide support for the updated measurements with a supplement when filing the cost report.

As an example:

	Square Feet	% of Total
Rental (Sub-Lease)	100	5%
Gift Shop	100	5
Non-Patient Care	200	10
Therapy Room	200	10
Patient Care	1,600	80
Total	2,000	100

Based on the above, 5% of each cost center's total adjusted costs would be allocated to each of the non-patient care areas and 10% to the therapy room. The total allocated to each cost center for non-patient care areas (Line 12) would be transferred to Schedule B-2 as an adjustment to allowable costs. The total allocated to each cost center for the therapy room (line 12.a) should be transferred to Schedule B-1A to calculate the non-Medicaid utilization portion of the cost. Column 1.a requires that pounds-of-laundry used in each non-patient care area and in the patient care area (in total) be listed so as to compute each area's percentage (%) relationship to the total. If pounds-of-laundry is used as an allocation statistic, at least 3 months of documented usage during the cost reporting period must have been obtained. The use of pounds-of-laundry is optional and can only be used for the distribution of Laundry costs. Square feet will be used when pounds-of-laundry is not selected.

Line 14: Sum of Lines 12 and 13. The total amount allocated (Line 14) should agree with total expenses, as adjusted (Line 1). The total square footage reported on Schedule B-5 should match the provider's most recent FRV.

Note that Schedule B-5 isolates only indirect expenses related to non-patient care and therapy activities. Any direct expenses (salary, supplies, etc.) applicable to non-patient care activities should be (1) reflected on Schedule B-3, Part II and thereby not require any adjustment because the amounts on Schedule B-3 are not included in allowable costs, or (2) listed as separate adjustments on Schedule B-4.

SCHEDULE B-6

The purpose of Schedule B-6 is to accumulate information on contractual services provided the facility by non-related parties for amounts of $100 or more per month or $1,200 or more per annum. This schedule should include all such services covered by contractual agreement, written or oral, such as full management services, accounting services only, medical (including Medical Director) or pharmaceutical services, therapists, dieticians, maintenance or laundry services, catering services, etc. Suppliers of products such as raw food, office supplies, etc. should not be included. Only one service should be listed on each line. If additional lines are required, submit that information on additional copies of Schedule B-6. (Use Line 10a for an aggregate

amount of all other contractual services that do not meet the dollar criteria for separate listing. Items on Line 10a must be allocated separately in Column 3 of allocation section of Schedule B-6.)

Column 1: The name of the service entity (corporation, partnership or individual) should be listed.

Columns 2-3: Owners of the entity and their ownership percentages should be listed only if the entity has less than five owners and if the total fees for a particular arrangement exceed the monetary criteria. If the entity listed in Column 1 is an individual, the individual's name should be reported in Column 2.

Column 4: A brief description of services provided should be listed.

Column 5: Provider number, if applicable, of entity.

Column 6: A brief description of the contractual arrangement is required.

Column 7: The total expense (line 11) should be provided and reconciled by cost center to that recorded in Schedule B-2 by completing Lines 12 through 19.

Column 8: Self-explanatory.

SCHEDULE B-7: VENTILATOR SERVICES PROGRAM COSTS SUMMARY

Report all costs incurred for the Ventilator Services Program on Schedule B-7. An adjustment should be made to remove both total direct and indirect costs specifically associated with ventilation services from the cost report. Note that some costs may be already removed as part of adjustments through Schedule B-5 – Allocation of Indirect Expenses to Non-Patient Care Areas as a result of separate Ventilator Services Unit.

Ventilator services patient days should be recorded by form of payment (Medicare, Medicaid (FFS), or Private and Other) and by whether or not the patient is on-site or on a hospital/leave days stay (Hospital/Leave days for Medicaid recipients should only include those days reimbursable under the Medicaid Program). A patient day is the care of one patient during the period between the census-taking hour of two successive days. When a patient is admitted and discharged on the same day, this must be counted as one inpatient day. Providers should ensure patient days listed on Schedule B-7 do not appear on Schedule A.

SCHEDULE C

The analysis of capital information will be obtained from a review of the general ledger accounts summarized in the column heading. Cross-referenced information has been provided in the schedule format and a careful review should be made to insure that all cross-referenced amounts are in agreement. Particular care should be taken so that the beginning of the period equity (Line 1) agrees with that reported in the prior year's cost report.

SCHEDULE D

The purpose of Schedule D is to accumulate information on prepaid and accrued expenses recorded during the cost report period.

Part I requires insurance information as follows:

Item 1: Specific information on all insurance policies in effect during the cost report period should be provided. This should include all policies that ended during the cost report period, as well as all policies that began during the period.

Column 1: The name of the insurance provider and/or the purpose of each policy should be listed and placed in the appropriate section.

Column 2: The period of coverage for each policy should be listed.

Column 3: The insurance type (commercial, self-insurance, captive) for each policy should be listed.

Column 4: If a prepaid account is utilized when recording insurance payments, the prepaid balance associated with each insurance policy should be listed.

Column 5: The amount expensed to the Administrative & General cost center should be listed. The total expense listed here should agree with the amounts reflected in Schedule B-2.

Column 6: The amount expensed to the Taxes and Insurance cost center should be listed. The total expense listed here should agree with the amounts reflected in Schedule B-2.

Item 2: Whether a prepaid account is utilized when recording insurance payments should be indicated.

Item 3: A brief description of the methodology used to calculate the prepaid balances supplied in Item 1, Column 4 should be provided.

NOTE: If a prepaid insurance analysis is maintained by the provider or cost report preparer, it may be submitted with the cost report in lieu of completing Part I of Schedule D.

Part II requires information on property taxes accrued and expensed during the cost report period as follows:

Item 4: Specific information on all property taxes expensed during the cost report period should be provided.

Column 1: The name of the jurisdiction receiving the property tax payments should be listed.

Column 2: The type of property tax (personal or real) should be listed.

Column 3: The amount expensed during the cost report period should be listed.

Item 5: Whether property tax accruals are recorded should be indicated.

Item 6: The balance in the Accrued Property Taxes general ledger account at the end of the cost report period should be listed.

Item 7: A brief description of the methodology used to calculate the balance reported in Item 6 should be provided.

Part III requires information on salaries, vacation time and payroll taxes accrued during the cost report period as follows:

Item 8: Whether salary, vacation time and payroll tax accruals are recorded should be indicated.

Item 9: Specific information on all salaries, vacation time and payroll tax accruals should be provided.

Column 1: The general ledger account number(s) where salary, vacation time and payroll tax accruals are recorded should be listed.

Column 2: The general ledger account name(s) where salary, vacation time and payroll tax accruals are recorded should be listed.

Column 3: The balance in each account listed in Columns 1 and 2 at the end of the cost report period should be listed.

Item 10: A brief description of the methodology used to calculate the balances reported in Item 9 should be provided.

SCHEDULE E

All lease arrangements must be summarized on this schedule; those leases that have not been capitalized should be listed in Part I and those leases that have been capitalized should be listed in Part II. If the Department has allowed a maximum lease as the result of an appraisal analysis, the actual expenses should be recorded here but the excess over the Departmental guidelines should be adjusted out in Column 2 Schedule B-2 under Property/Related allowable lease expenses.

The column headings are self-explanatory as to the information required. Any lease with a related party (See Instructions to Schedule H for information on what is a related party) should be listed in the appropriate section of Schedule H. This requirement applies whether the lease has or has not been capitalized. The total rent expense, or amortization expense in the case of capitalized leases, must cross-reference to the other schedules indicated.

If any leases listed are part of a sale leaseback arrangement, the provider must attach a supporting explanation as to the complete terms of such arrangement.

SCHEDULE F

List the total interest expense incurred for the period. Be sure to include interest expense information on loans paid off during the period. The total interest expense should agree with the amounts reflected in Schedule B-2.

SCHEDULE G AND G-1

Schedule G is a summary of the current year's nursing hours and employee benefits. Nursing hours should be itemized by employee hours and contractor hours. Employee benefits information has been moved from the questionnaire to Schedule G. The schedule is self-explanatory; however, be sure that total benefits and payroll taxes equal the total of Schedule B-2 amounts including the expenses in account 930.00 for Nurse Aide Training and Testing.

Schedule G-1 is used to list all compensation by position or title that exceed an annual salary of $62,102 or an hourly wage rate of $29.86. The following employees should also be reported on Schedule G-1 regardless of compensation:

1. Administrator
2. Assistant Administrator
3. Director of Nursing
4. Assistant Director of Nursing
5. Activities Director
6. Marketing Director
7. Staff Development Coordinator
8. Maintenance Director
9. Admissions Director
10. Clinical Liaison
11. Business Office Manager

All employees who perform job duties designed to increase patient utilization of the facility should also be listed regardless of compensation. If an employee performs non-allowable job duties, this should be indicated in column 8. The percentage of time spent on non-allowable job duties should be listed in column 9. Employees who are owners or non-owner related parties should also be listed. Cost center location for each listing must be included. (All individuals with portions of salary cost and/or hours at other facilities or Non-Medicaid entities must be listed with an asterisk designated after each amount.)

SCHEDULE H

All related party transactions are to be summarized in Part I of this Schedule. A related party may be a corporation, partnership, or individual. (Refer to Chapter 10 of CMS-15 for an explanation of what constitutes a related party and how this can affect allowable costs.) In general, related to the provider means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, supplies, etc. Further, costs applicable to services, facilities and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related party. Such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Where the cost of a related party is included in allowable costs, supporting financial statements of the related party cost for the cost report period must be furnished.

However, as stated in CMS-15 and the policies and procedures manual by reference, payments to related parties operating on an arms-length basis would be included in allowable costs on the basis of charges. Refer to Section 1010 of CMS-15 for further details on this exception to the related party principle.

The break out of information in Schedule B-2 provides for segregation of all related party transactions by cost center. All amounts included in the related party categories in Schedule B-2 must be detailed in the appropriate section of Schedule H and all items in Schedule H must be classified in the related party categories in Schedule B-2.

Each category of related party data in Part I has a column established to capture any adjustments to allowable costs, which is essentially the difference between the total paid by the provider and the cost to the related party. The following is additional information applicable to Items 1 through 4.

Item 1: The non-allowable rent expense in Column 5 is the difference between either the amount included in expense (Column 2), or the amount amortized (Column 3) per Schedule E and the cost to the related party (Column 4) which includes depreciation, insurance, taxes, interest and other costs paid by the lessor. Lines 6 through 11 are provided to accumulate the related party cost.

Item 2: If an asset has been purchased from a related party, the depreciation cannot exceed that which would have been recorded by the related party had the asset not been purchased by the provider. Thus the non-allowable expense in Column 8 represents the difference in the total depreciation recorded by the provider in Column 6 and that computed as the cost to the related party in Column 7. Columns 3 through 5 require historical cost information relating to the related party for the computation in Columns 6 through 8.

Item 3: Generally, interest paid to partners, stockholders and related parties (Column 6) is not an allowable cost, except for loans made before July 1, 1966, provided the terms and conditions of such loans have not been subsequently modified (Refer to CMS-15, Chapter 2 for further information). Lines 17 through 22 are provided to list all related party payables and receivables. The information required in columns 2 and 3 is only for loans paid off during the current period.

Item 4: The information requested for purchases and services from related parties (contracted services, purchases of supplies, etc.) and home office allocations should be summarized in the space provided. The amount included in expense (Column 4) should agree with schedule I-1 of a Home Office Cost Report and the cost to the related party (Column 6) should agree with schedule I-4 of a Home Office Cost Report. The amount recorded as expense (Column 4) in excess of the cost to the related party (Column 6) should be entered as a non-allowable expense in Column 7. The total recorded expenses of Item 4 on line 37 should be reconciled by completing lines 39 through 46 to the amount of related party expenses recorded by cost center in Schedule B-2. Note that each line item(s) listed represented by a separate set of books should be supported by a separate Home Office Cost Report. If the Part I first question is a "No" answer, Part II must still be filled out is applicable.

Part II requires additional information on related parties, including ownership, employees and officers of the provider as follows:

Item 1: This section summarizes all the related parties listed in Part I. The name of the related party (corporation, partnership, or individual) and the provider number, if applicable, should be listed in Columns 1 and 2. If the related party is a corporation or partnership, the stockholders or partners are required to disclose their names and ownership percentages in Columns 3 and 4 respectively. If the related party is an individual, repeat the name from Column 1 in Column 3. A brief description of services provided should be included in Column 5. Columns 6 and 7 should indicate the line number in Part I where the detail and dollar amounts are included in expense. It will also be necessary to list in Columns 8 and 9 any other services provided (and applicable provider number) by the related party which are reimbursed through other Medicaid programs. As an example, a related party providing some form of contractual services may be a physician, pharmacist, physical therapist, etc. who also bills for services provided individually to recipients.

Item 2: The name(s) of the owner(s), of the provider, (corporation, partnership, or individual) and percentage owned should be listed in Column 1. If the owner is a corporation or partnership, the stockholders or partners, their ownership percentages should be listed in Columns 2 and 3 respectively. If the entity is an individual, repeat the name and percentage of ownership from Column 1 in Columns 2 and 3. Columns 4 and 5 should detail the name and provider number of any other nursing homes in which the owning entity, the individual owners or their relatives (parent, spouse, child, grandparent, sibling and in-law) have interest. Attach a separate page if necessary. It will also be necessary to list in Columns 6 and 7 any other services provided (and applicable provider number) by the owning entity or the individual owners which are reimbursed through other Medicaid programs. As an example, an owner may be a physician, pharmacist, physical therapist, etc., who also bills for services provided individually to recipients.

Item 3: Each employee or officer who (1) receives compensation and (2) is an owner (either directly or through beneficial interest) or is a relative (as defined in instructions to Item 2 above) of an owner, the Administrator or Assistant Administrator must be listed in this section. The relationship is to be described in Column 3. The Administrator and Assistant Administrator must be listed regardless of ownership interest. In addition, all Directors should be listed by individual and the total Director's fees listed in Column 7 should agree with that in Schedule B-2. Total other compensation must include the amount of compensation resulting from the personal use of any autos, lodgings or any other benefits not included in the total compensation amount.

SCHEDULE I

Column 1: Information on leased facilities (not equipment) is to be provided in this column. The detail information on the lease arrangements would be provided in Scheduled E.

Columns 2-4: Information on purchased facilities is to be provided in these columns. The total cost and depreciation will cross-reference to Schedule D as indicated on the schedule.

GENERAL AND PROFESSIONAL LIABILITY INSURANCE INFORMATION (GL/PL)

The purpose of the GL/PL questionnaire is to specify the GL/PL expenses incurred during the cost reporting period and the type(s) of policies (self-insurance trust, captive insurance, commercial insurance, other).

Self-Insurance Trust: The provider must meet the criteria outlined in CMS 15-2162.7 to expense the premiums paid on the insurance policy. If any of these criteria are not met, then the provider can only expense amounts paid for claims during the year.

Captive Insurance: The provider must meet the criteria outlined in CMS 15-2162.2 to expense the premiums paid on the captive insurance policy. If any of these criteria are not met, the expense is disallowed.

Commercial Insurance: The provider should determine whether a cost is allowable and how to classify the expense per HCFA 15-1 section 108 and DCH Policies and Procedures.

If the expense reported on the GL/PL questionnaire does not cover the entire fiscal year, the provider should indicate the periods

included on Line A. Additionally, if GL/PL expense is included in an account other than Sch. B-2, Line 117 (Acct. 905.96), the provider should indicate the amount reported elsewhere on Line C and the schedule and line where it is reported on Line D.

Costs for general and professional liability insurance expense, as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to the Administrative and General cost center Standard Per Diem.

Resident Trust Fund (RTF)

The purpose of the RTF tab is to provide information regarding the RTF account that is applicable to the cost reporting period.

Line 1: The provider should select Yes or No in response to the question in Line 1. If Yes is selected, the provider should add the per books amount and RTF bank account balance as of the end of the cost reporting period. If a variance of $10 or more exists, a detailed explanation must be provided.

Line 2: The provider should select Yes or No in response to the question in Line 2. If Yes is selected, the provider should add the frequency in which the bank accounts are reconciled.

Line 3: The provider should select Yes or No in response to the question in Line 3.

Line 4: The provider should select Yes or No in response to the question in Line 4.

Line 5: The provider should select Yes or No in response to the question in Line 5.

Line 6: The provider should input the cash on hand related to the RTF. All residents' personal funds that do not exceed $50 can be in a non-interest bearing account, or petty cash fund.

Line 7: The provider should input the cash in all other accounts related to the RTF. All residents' personal funds that do not exceed $50 can be in a non-interest bearing account, or petty cash fund.

Line 8: The provider should input the total RTF amount from all sources in Line 8.

QUESTIONNAIRE

The purpose of the Questionnaire tab is to provide additional information related to Schedule A, Schedule B-2, Vehicles and Fair Rental Value Projects.

Line 1: The provider should select Yes, No, or N/A in response to the question in Line 1. If No is selected, the provider should include an explanation with the cost report submission.

Line 2: The provider should select Yes, No, or N/A in response to the question in Line 2. If No is selected, the provider should include an explanation with the cost report submission.

Line 3: The provider should utilize the table provided to itemize dues and subscriptions. The total reported should tie to Schedule B-2, Line 112. Providers should refer to DCH 1002.1(k) to determine allowable dues and subscriptions.

Line 4: The provider should utilize the table provided to identify expenses related to travel, conventions, education, and other. The total should tie to Schedule B-2, Line 113.

Line 5: The provider should utilize the table provided to itemize advertising expenses. The total reported should tie to Schedule B-2, Line 115. Providers should refer to CMS 2136.2 and DCH 1002.1(k) to determine allowable advertising expenses.

Line 6: The provider should indicate whether any of the following are owned or leased by the facility: airplane, recreational vehicle, boat or yacht, recreational facility (i.e. pool, tennis court, etc). If any of these assets are owned or leased by the facility, the provider should attach a detail listing to the cost report describing the use, who uses the asset(s), and the amount of expense related to personal use.

Line 7: The provider should answer Yes or No in response to the question in Line 9. If any transportation vehicles maintained by the provider are used for patient related uses, the provider should utilize the table provided to identify pertinent information related to the vehicle(s).

Line 8: The provider should select Yes or No in response to the question in Line 10. If Yes is selected, the provider should indicate whether an Initial Startup and FRVS Update Request Form was submitted and the date of submission.