Hospital Based Cost Report

September 13, 2021

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Who We Are

- Myers and Stauffer is a CPA firm with over 40 years of experience that specializes in government healthcare.
- We partner with federal, state, and local agencies to perform a variety of services. Everything from consulting and litigation support to rate setting and compliance reviews.
- Currently, Myers and Stauffer has 19 offices across the nation and has over 900 dedicated team members.
- The Atlanta office opened in 2008 and currently has over 70 employees.
- FY2021 will be the fifth year that Myers and Stauffer have been performing the Skilled Nursing Facility (SNF) reviews and examinations on behalf of the Department of Community Health (DCH).

For more information, visit www.mslc.com.

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Medicaid Nursing Facility Hospital Based Cost Report

- Nursing homes are required to submit a cost report detailing their revenues and expenses for the year.
- Hospital based facilities are allowed to use a year end other than June 30. The year end will coincide with the year end used on the related hospital's Medicare cost report.
- The costs are classified to various cost centers on Schedule B-2 and the cost centers are reimbursed at different rates.

Hospital Based Cost Report: Checklist and Resources

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Provider Manuals

The DCH policy and procedure manuals are available for providers and cost report preparers. To download the most recent copies of these manuals, please visit: https://www.mmis.georgia.gov/portal/Default.aspx?tabid=20

The following manuals will be beneficial for cost report preparers:

1. Part 1 Policies and Procedures for Medicaid PeachCare for Kids

   This manual details the general requirements and policies for all Medicaid provider's in the state. Included in this manual are the provider's appeal rights and procedures.

2. Nursing Facility Services Policy Manual

   This manual contains the policies and procedures specific to operators of Skilled Nursing Facilities.

3. Uniform Chart of Accounts Manual

   This manual provides the chart of accounts used on the Medicaid cost report and also includes excellent guidance on the classification of specific expenses.

Checklist

New for FY2021

Every provider should complete the checklist as the cost report is prepared. The checklist should be submitted with the cost report.

The checklist includes information that will ensure that the cost report is completed accurately.

Georgia Department of Community Health - Hospital Based Nursing Facility Cost Report Checklist
This Checklist Must Be Submitted with the Cost Report

Name of Facility:	Provider Name
Medicaid Provider Number:	Provider Number
Period Ended:	6/30/2021

SCHEDULE	SCHEDULE DESCRIPTION		REFERENCE	YES	N/A
PAGE i			Facility email address and facility email address contact's name should be the individual to contact for questions regarding the cost report.		
PAGE i			Submit nursing home license if a name change has occurred since the prior cost report filing period or if the name in the drop down does not match the current name of the provider.		
A	Occupancy and Rate Data				
B	Statement of Operations				
B-1	Supporting Schedules to Statement of Operations - Revenues				
B-1A	Calculations of Ancillary Cost Adjustments		Verify row 45 does not include "Please repress calculation button at top!"		
B-2	Supporting Schedules to Statement of Operations - Operating Expenses		Failure to meet the requirements below could result in a request to refile the cost report. 1. The total for Schedule B-2, Line 40, Column 2 (Per Facility Books), should tie to the amount on Medicare Worksheet A, Column 3 (Total (col. 1 + col. 2)) for the Skilled Nursing Facility line, which is generally Line 44, Column 3. 2. The total for Schedule B-2, Line 40, Column 3 (Medicare Reclassifications), should tie to the amount on Medicare Worksheet A, Column 4 (Reclassifications (See A-6)) for the Skilled Nursing Facility line, which is generally Line 44, Column 4. 3. The total for Schedule B-2, Line 40, Column 4 (Medicare Adjustments), should tie to the amount on Medicare Worksheet A, Column 6 (Adjustments (See A-8)) for the Skilled Nursing Facility line, which is generally Line 44, Column 6. 4. The total for Schedule B-2, Line 40, Column 6 (Total Nursing Facility Amount), should tie to the amount on Medicare Worksheet B, Part I, Column 26 (Total) for the Skilled Nursing Facility line, which is generally Line 44, Column 26. 5. The New Capital Costs from Medicare Worksheet B, Part II should be entered as negative amounts in Schedule B-2, Column 7 (New Capital Costs), Lines 1-33 .		
B-3	Supporting Schedules to Statement of Operations - Other Revenues and Non-Operating Expenses		Description for accounts 498.00 and 499.00 should provide insight into revenues. "Miscellaneous" is not an adequate description. Prior year income should include enough detail to determine the source of the revenue.		
B-4	Adjustments to Expenses				

Cost Report Instructions

In addition to the provider manuals and checklist, there is a brief 10 page document designed to assist cost report preparers.

The cost report instructions provide further guidance for each schedule of the cost report, as well as providing some specific examples on completing the schedules.

The cost report instructions, cost report template, and checklist can all be found on DCH's website:

https://dch.georgia.gov/providers/provider-types/nursing-home-providers/cost-reports/hospital-based

Hospital Based Cost Report

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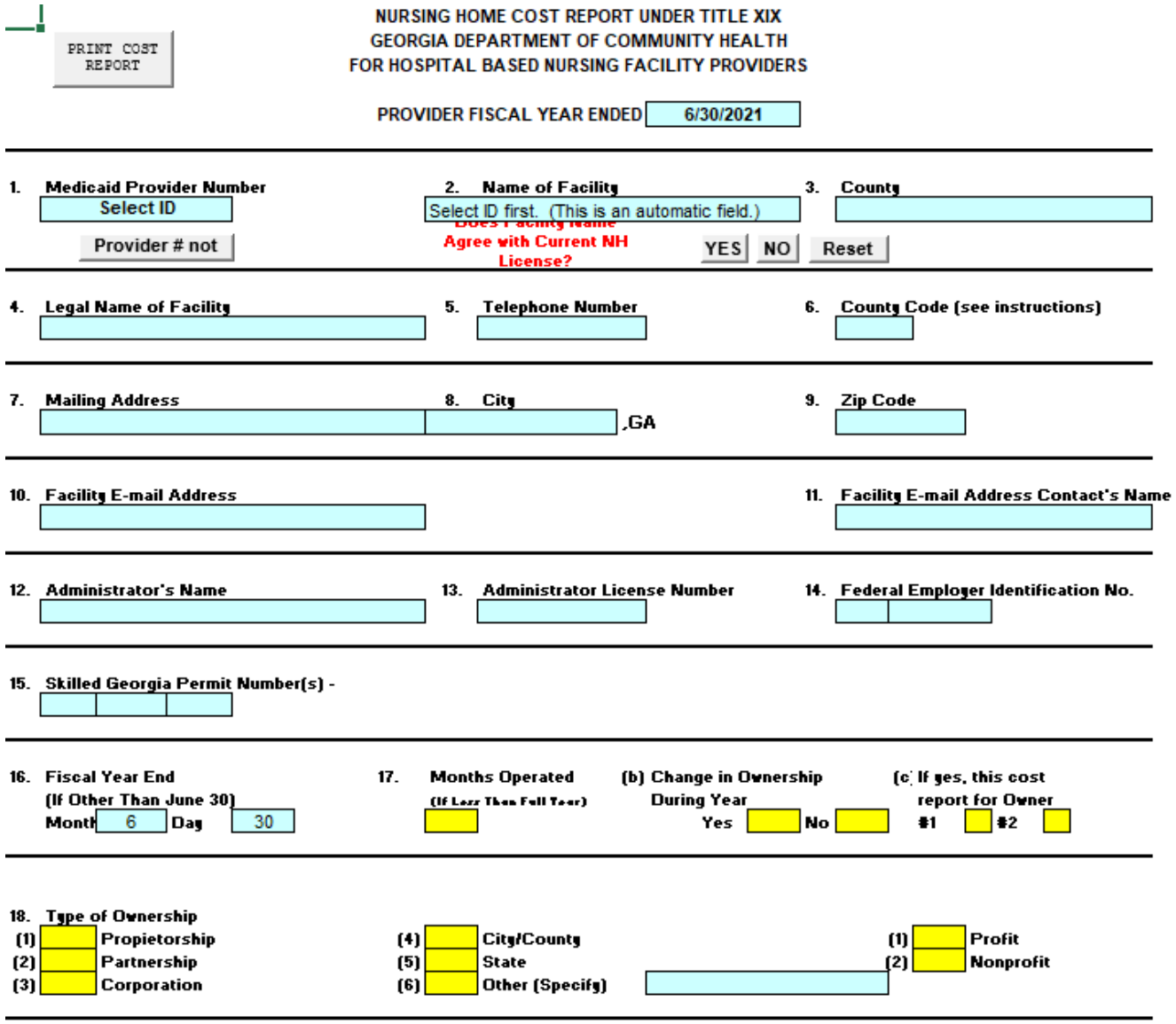
Page i



PRINT COST REPORT

NURSING HOME COST REPORT UNDER TITLE XIX
GEORGIA DEPARTMENT OF COMMUNITY HEALTH
FOR HOSPITAL BASED NURSING FACILITY PROVIDERS

PROVIDER FISCAL YEAR ENDED 6/30/2021

1. Medicaid Provider Number — Select ID — Provider # not
2. Name of Facility — Select ID first. (This is an automatic field.) — Does Facility Name Agree with Current NH License? YES NO Reset
3. County
4. Legal Name of Facility
5. Telephone Number
6. County Code (see instructions)
7. Mailing Address
8. City ,GA
9. Zip Code
10. Facility E-mail Address
11. Facility E-mail Address Contact's Name
12. Administrator's Name
13. Administrator License Number
14. Federal Employer Identification No.
15. Skilled Georgia Permit Number(s) -
16. Fiscal Year End (If Other Than June 30) Month 6 Day 30
17. Months Operated (If Less Than Full Year)
(b) Change in Ownership During Year Yes No
(c) If yes, this cost report for Owner #1 #2
18. Type of Ownership
(1) Propietorship
(2) Partnership
(3) Corporation
(4) City/County
(5) State
(6) Other (Specify)
(1) Profit
(2) Nonprofit

General facility information.

Facility e-mail and contact should be for the person to contact regarding cost report questions.

If a change of ownership occurred, indicate if this is the first or second owner cost report and the number of months operated.

Documents ownership and non-profit status.

Page i

19. Type of Facility Certified (Provide number of beds licensed for each type facility)

		No. of Beds
1.	Entirely Nursing Facility (NF)	
2.	Non-Skilled Nursing Beds	

20. Change in Classification/Name

	FROM	TO	EFFECTIVE DATE
Class:			
Name:			

21. For the cost centers for which the facility shared the cost of services with another service provider, enter the number of beds involved in the appropriate column/s:

	number of beds	routine and special	dietary	laund. hskpg., op. and maint.	admin. and gen.
this facility					
other provider/s					

General facility information.

Check Figures

	CHECK FIGURES (NOTE: This analysis may produce a "NUMBERS DO NOT TIE!!!" result, even if the numbers are essentially equal, because of rounding. If this is the case, simply note that the numbers are materially equal in the explanation column.)			******If numbers do not tie, provide an explanation here:**
1.	Sch. B-2, Line 39, Col. 6	1,029,460		
	Detail of Property and Related Costs, Total	1,029,460		
	Variance			
2.	Sch. B-2, Line 40, Col. 9	57,453		
	Sch. B-4, Final Line, Col. 2	57,453		
	Variance			
3.	Sch. B-2, Line 19, Col. 11	446,614		
	Sch. B-5, Line 1, Col. 2 & 2a	446,614		
	Variance			
4.	Sch. B-2, Line 23, Col. 11	608,771		
	Sch. B-5, Line 1, Col. 3	608,771		
	Variance			
5.	Sch. B-2, Detail of P&R Costs, Taxes and Insurance	10,849		
	Sch. B-5, Line 1, Col. 4	10,849		
	Variance			
6.	Sch. A, Line 19	250		
	Sch. A, Line 20	250		
	Sch. A, Line 21	189		
	Sch. A, Line 22	N/A		
	Sch. A, Line 24	N/A		
	Sch. A, Line 25	N/A		

Tab allows the provider to verify that important figures tie across cost report.

Schedule A

Provider Name: Select ID first. (This is an automatic field.) | Select ID
OCCUPANCY AND RATE DATA | 6/30/2021
SCHEDULE A

Part I - Inpatient Days

	1 Medicare	2 Private & Other On-Site	3 Private & Other Hospital/ Leave	4 (FFS)	5 Medicaid (CMO)	6	7 TOTAL	8 TOTAL	9 TOTALS
		On-Site	Hospital/Leave	On-Site	On-Site	Hospital/Leave	On-Site	Hospital/Leave	TOTALS
1. July	-	-	-	-	-	-	-	-	-
2. August	-	-	-	-	-	-	-	-	-
3. September	-	-	-	-	-	-	-	-	-
4. October	-	-	-	-	-	-	-	-	-
5. November	-	-	-	-	-	-	-	-	-
6. December	-	-	-	-	-	-	-	-	-
7. January	-	-	-	-	-	-	-	-	-
8. February	-	-	-	-	-	-	-	-	-
9. March	-	-	-	-	-	-	-	-	-
10. April	-	-	-	-	-	-	-	-	-
11. May	-	-	-	-	-	-	-	-	-
12. June	-	-	-	-	-	-	-	-	-
13. TOTALS	-	-	-	-	-	-	-	-	-

PART II- Nursing Facility Bed Capacity

	Nursing Facility	Hospital
14. Certified beds at beginning of period		
15. Certified beds at end of period		
16. Date(s) of change in number of certified beds, if applicable (month/day)		
17. Bed days available during the period (See Instructions)	-	-

Part III - Percent Occupancy

18. Total from line 13, Part I divided by line 17, Part II	0.0%

Monthly census totals are included in Part 1 of schedule A. These numbers should tie to the census detail reports.

Note that the total on-site days (column 7) and Medicaid on-site days (column 4) are used in schedule B-1A calculations.

The certified beds should tie to the nursing home license and hospital beds should tie to the hospital license.

Schedule B

Provider No. Select ID
6/30/2021
Provider Name: Select ID first. (This is an automatic field.)
STATEMENT OF OPERATIONS
PERIOD ENDED 6/30/2021
SCHEDULE B

1	2	3	4
	Reference	Per Books (operating expenses Per Medicare Cost Report)	As Adjusted
REVENUES:	SCHEDULE B-1		
1. Routine Services	Line 7	-	
2. Ancillary Services	Line 21	-	
3. Less - Allowances and Adjustments	Line 40	-	
4. Net Revenues		-	
OPERATING EXPENSES:	SCHEDULE B-2		
5. Routine Services	Line 6	-	-
6. Special Services	Line 11	-	-
7. Dietary	Line 15	-	-
8. Laundry and Housekeeping	Line 19	-	-
9. Operation and Maintenance of Plant	Line 23	-	-
10. Administrative and General	Line 34	-	-
11. Property and Related	Line 39	-	-
12. Total Operating Expenses	Line 40	-	-
13. Gross Profit (Loss) from Operations (Line 4 - Line 13)		-	
OTHER REVENUES AND NON-OPERATING EXPENSES:	SCHEDULE B-3		
14. Other Revenues	Line 41	-	
15. Non-Operating Expenses	Line 58	-	
16. Net Income (Loss) Before Income Taxes		-	
17. Provision for Income Taxes			
18. Net Income (Loss)		-	

Column 2 references the associated Schedule and line that corresponds to the amounts shown in column 3.

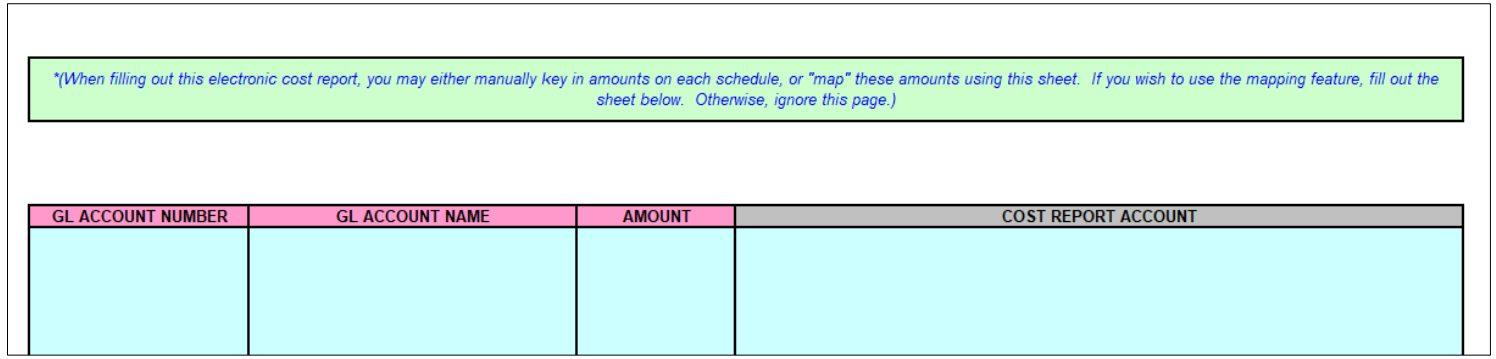
Column 3 summarizes the amounts that are recorded on the nursing home's general ledger and adjusted or allocated through the Medicare cost report. The amount corresponds to Column 8 on schedule B-2.

Column 4 summarizes the adjusted costs by cost center and corresponds to Column 11 on schedule B-2.

Mapping

Providers can include the mapping (grouper/crosswalk) of the GL accounts that make up the revenues and expenses included on the cost report.

Note: This can be supplied as a separate attachment and submitted with the cost report, if desired.



*(When filling out this electronic cost report, you may either manually key in amounts on each schedule, or "map" these amounts using this sheet. If you wish to use the mapping feature, fill out the sheet below. Otherwise, ignore this page.)

GL ACCOUNT NUMBER	GL ACCOUNT NAME	AMOUNT	COST REPORT ACCOUNT

Not Completed

GL ACCOUNT NUMBER	GL ACCOUNT NAME	AMOUNT	COST REPORT ACCOUNT
30[redacted]00	Private Revenue	[redacted]	300.11 Nursing Facility - Private
30[redacted]00	Medicare Part A Revenue		300.12 Nursing Facility - Medicare
30[redacted]00	Medicaid Revenue		300.13 Nursing Facility - Medicaid
30[redacted]07	Medicaid PMP		300.13 Nursing Facility - Medicaid
30[redacted]08	Medicaid Hospice HPP		300.16 Nursing Facility - Other
30[redacted]00	Hospice Revenue Related		300.16 Nursing Facility - Other
30[redacted]02	Hospice Private Pay Rev		300.16 Nursing Facility - Other
30[redacted]05	Hospice Medicaid Pending HMP		300.16 Nursing Facility - Other
30[redacted]00	Insurance Revenue		300.16 Nursing Facility - Other
30[redacted]00	PruittHealth Premier		300.16 Nursing Facility - Other
30[redacted]00	Skilled in Place		300.16 Nursing Facility - Other

Completed

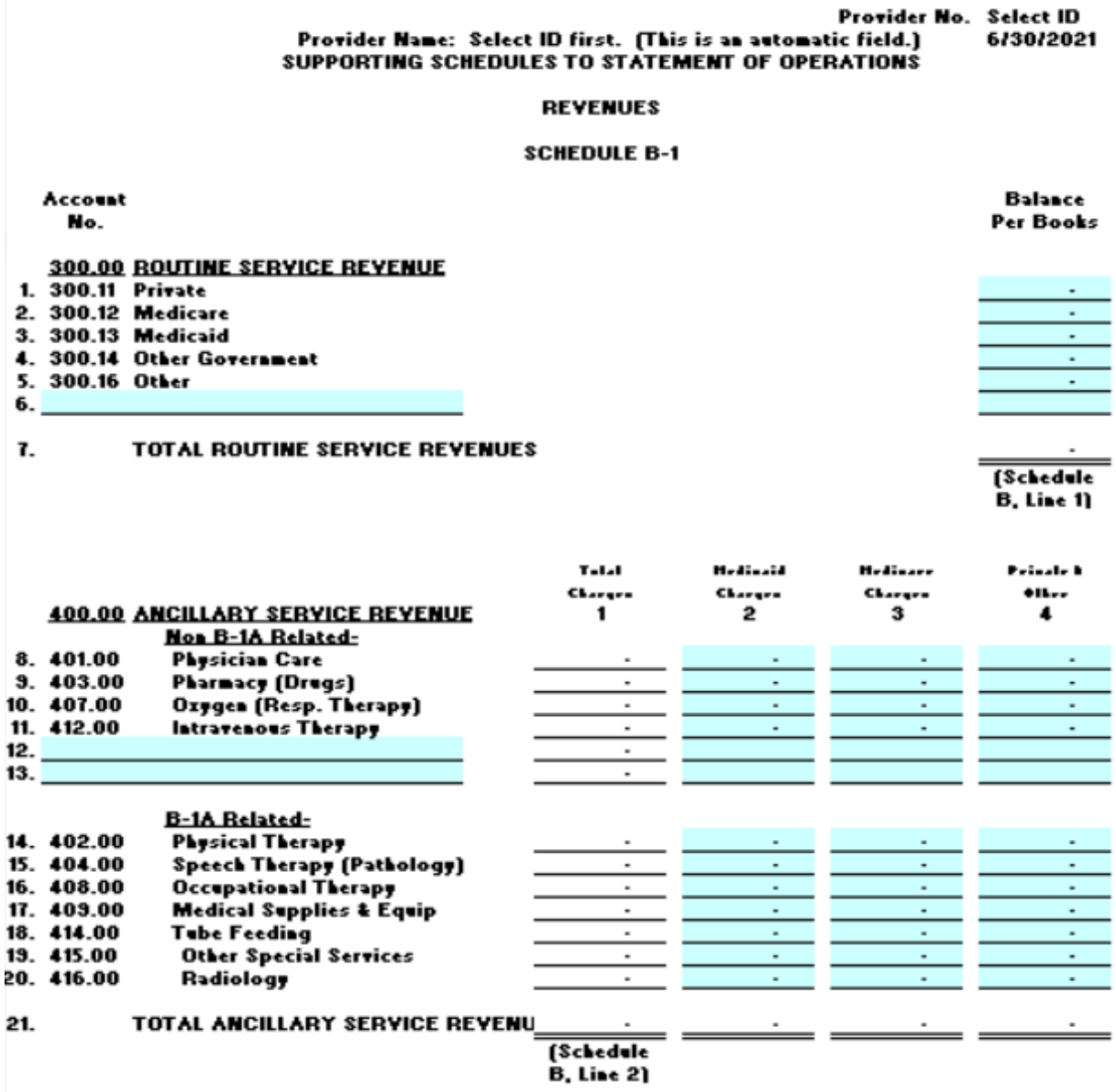
Lines 1-7 include various revenues that should tie to the general ledger.

The next 14 lines of Schedule B-1 gives the breakdown of the amount shown on Schedule B, line 2. The columns break down the total charges for each type of ancillary service by payer; Medicaid, Medicare, Private & Other.

The rows break down the ancillary service revenue by type of ancillary services. Lines 8-13 are non B-1A and are treated the same as lines 1-7.

Lines 14-20 are B-1A related and feed into the calculation done on Schedule B-1A.

Schedule B-1



Provider No. Select ID
Provider Name: Select ID first. (This is an automatic field.) 6/30/2021
SUPPORTING SCHEDULES TO STATEMENT OF OPERATIONS

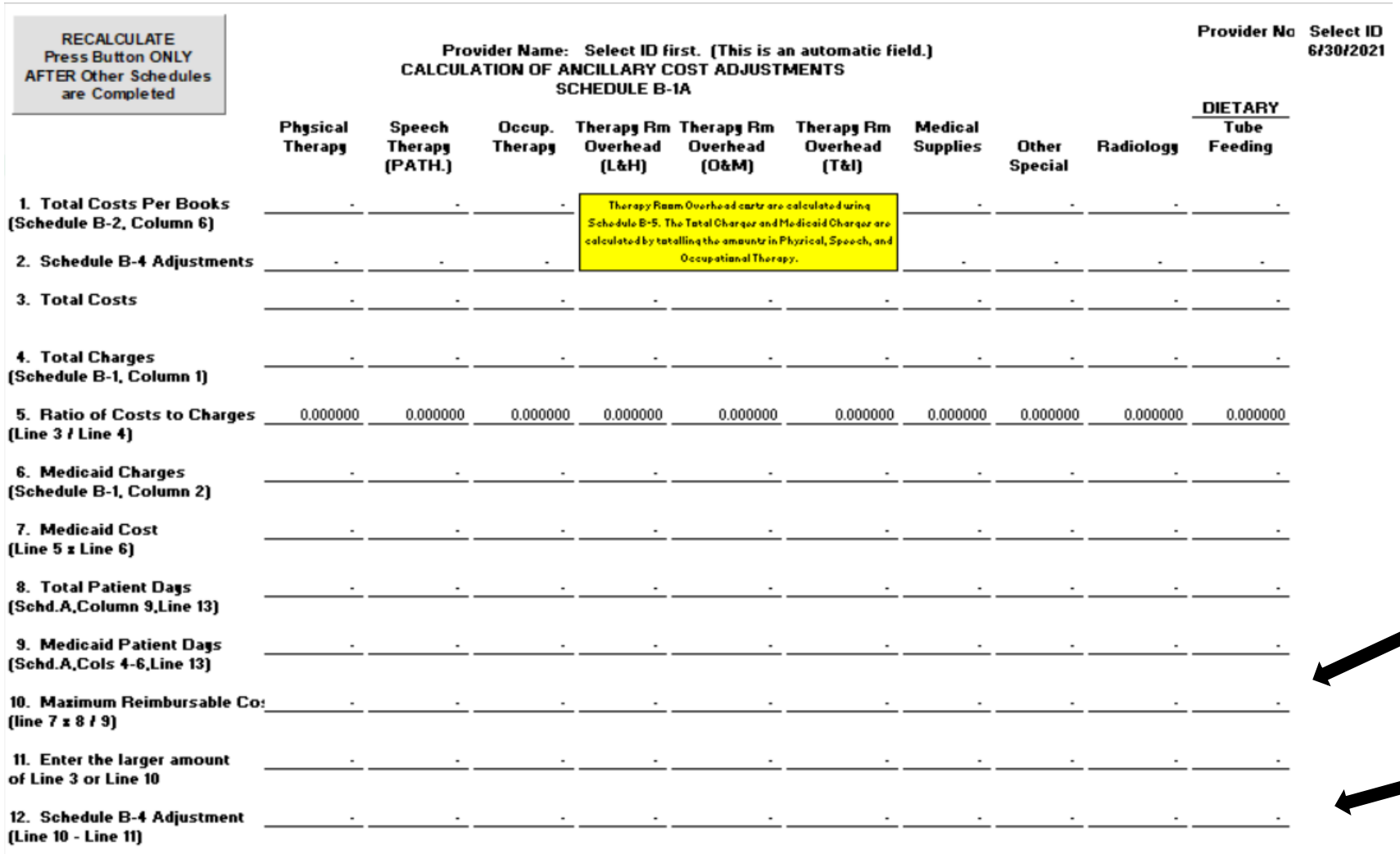
REVENUES

SCHEDULE B-1

	Account No.		Balance Per Books
	300.00	ROUTINE SERVICE REVENUE	
1.	300.11	Private	-
2.	300.12	Medicare	-
3.	300.13	Medicaid	-
4.	300.14	Other Government	-
5.	300.16	Other	-
6.			
7.		TOTAL ROUTINE SERVICE REVENUES	-
			(Schedule B, Line 1)

	Account No.		Total Charges 1	Medicaid Charges 2	Medicare Charges 3	Private & Other 4
	400.00	ANCILLARY SERVICE REVENUE				
		Non B-1A Related-				
8.	401.00	Physician Care	-	-	-	-
9.	403.00	Pharmacy (Drugs)	-	-	-	-
10.	407.00	Oxygen (Resp. Therapy)	-	-	-	-
11.	412.00	Intravenous Therapy	-	-	-	-
12.			-			
13.			-			
		B-1A Related-				
14.	402.00	Physical Therapy	-	-	-	-
15.	404.00	Speech Therapy (Pathology)	-	-	-	-
16.	408.00	Occupational Therapy	-	-	-	-
17.	409.00	Medical Supplies & Equip	-	-	-	-
18.	414.00	Tube Feeding	-	-	-	-
19.	415.00	Other Special Services	-	-	-	-
20.	416.00	Radiology	-	-	-	-
21.		TOTAL ANCILLARY SERVICE REVENU	-	-	-	-
			(Schedule B, Line 2)			

Schedule B-1A



RECALCULATE Press Button ONLY AFTER Other Schedules are Completed

Provider Name: Select ID first. (This is an automatic field.)
CALCULATION OF ANCILLARY COST ADJUSTMENTS
SCHEDULE B-1A

Provider No | Select ID 6/30/2021

	Physical Therapy	Speech Therapy (PATH.)	Occup. Therapy	Therapy Rm Overhead (L&H)	Therapy Rm Overhead (O&M)	Therapy Rm Overhead (T&I)	Medical Supplies	Other Special	Radiology	DIETARY Tube Feeding
1. Total Costs Per Books (Schedule B-2, Column 6)	-	-	-	Therapy Room Overhead costs are calculated during Schedule B-5. The Total Charges and Medicaid Charges are calculated by totalling the amounts in Physical, Speech, and Occupational Therapy.			-	-	-	-
2. Schedule B-4 Adjustments	-	-	-				-	-	-	-
3. Total Costs	-	-	-	-	-	-	-	-	-	-
4. Total Charges (Schedule B-1, Column 1)	-	-	-	-	-	-	-	-	-	-
5. Ratio of Costs to Charges (Line 3 / Line 4)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000
6. Medicaid Charges (Schedule B-1, Column 2)	-	-	-	-	-	-	-	-	-	-
7. Medicaid Cost (Line 5 x Line 6)	-	-	-	-	-	-	-	-	-	-
8. Total Patient Days (Schd.A,Column 9,Line 13)	-	-	-	-	-	-	-	-	-	-
9. Medicaid Patient Days (Schd.A,Cols 4-6,Line 13)	-	-	-	-	-	-	-	-	-	-
10. Maximum Reimbursable Cos (line 7 x 8 / 9)	-	-	-	-	-	-	-	-	-	-
11. Enter the larger amount of Line 3 or Line 10	-	-	-	-	-	-	-	-	-	-
12. Schedule B-4 Adjustment (Line 10 - Line 11)	-	-	-	-	-	-	-	-	-	-

The various types of ancillary services that require a B-1A calculation are listed across the top. These services are reimbursable by Medicaid and Medicare.

The B-1A calculation determines the portion of cost reimbursable (allowable) by Medicaid on Line 10.

The remaining costs listed on Line 12 should be removed from the allowable costs through a schedule B-4 adjustment.

Schedule B-1A

RECALCULATE
Press Button ONLY
AFTER Other Schedules
are Completed

Provider Name: Select ID first. (This is an automatic field.) Provider No Select ID
CALCULATION OF ANCILLARY COST ADJUSTMENTS 6/30/2021
SCHEDULE B-1A

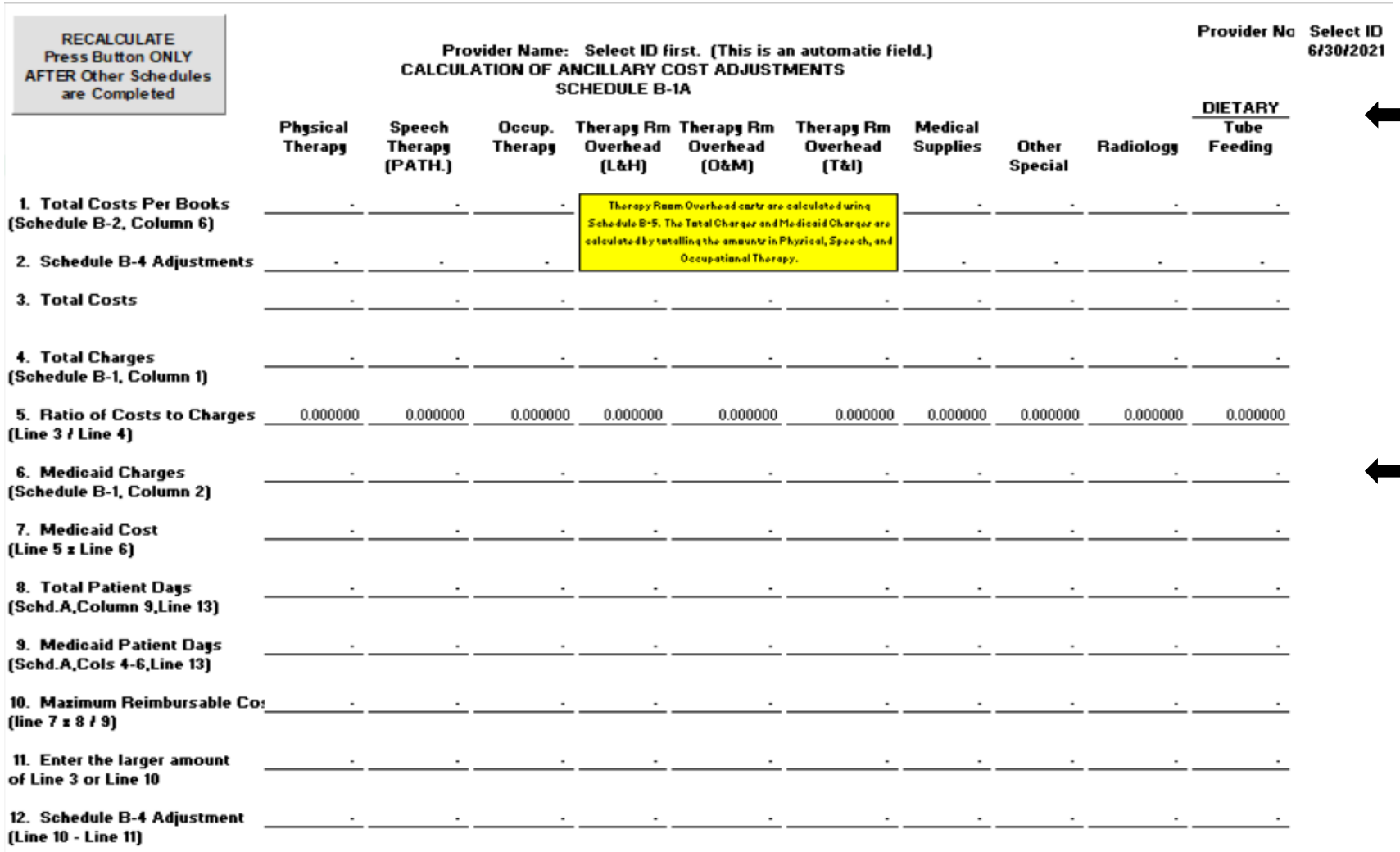
	Physical Therapy	Speech Therapy (PATH.)	Occup. Therapy	Therapy Rm Overhead (L&H)	Therapy Rm Overhead (O&M)	Therapy Rm Overhead (T&I)	Medical Supplies	Other Special	Radiology	DIETARY Tube Feeding
1. Total Costs Per Books (Schedule B-2, Column 6)	-	-	-	Therapy Room Overhead costs are calculated using Schedule B-5. The Total Charges and Medicaid Charges are calculated by totalling the amounts in Physical, Speech, and Occupational Therapy.			-	-	-	-
2. Schedule B-4 Adjustments	-	-	-				-	-	-	-
3. Total Costs	-	-	-	-	-	-	-	-	-	-
4. Total Charges (Schedule B-1, Column 1)	-	-	-	-	-	-	-	-	-	-
5. Ratio of Costs to Charges (Line 3 / Line 4)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000
6. Medicaid Charges (Schedule B-1, Column 2)	-	-	-	-	-	-	-	-	-	-
7. Medicaid Cost (Line 5 x Line 6)	-	-	-	-	-	-	-	-	-	-
8. Total Patient Days (Schd.A,Column 9,Line 13)	-	-	-	-	-	-	-	-	-	-
9. Medicaid Patient Days (Schd.A,Cols 4-6,Line 13)	-	-	-	-	-	-	-	-	-	-
10. Maximum Reimbursable Cos (line 7 x 8 / 9)	-	-	-	-	-	-	-	-	-	-
11. Enter the larger amount of Line 3 or Line 10	-	-	-	-	-	-	-	-	-	-
12. Schedule B-4 Adjustment (Line 10 - Line 11)	-	-	-	-	-	-	-	-	-	-

The amounts brought in from other schedules to lines 1, 2 and 4 are used to calculate Total Costs (1+2) on line 3 and the Ratio of Costs to Charges (3/4) on line 5.

The Ratio of Costs to Charges calculated on line 5 is used along with the Medicaid Charges on line 6 to calculate a Medicaid cost (5X6) on line 7.

Then, the Total Patient Days and the Medicaid Patient Days are used to gross up the Medicaid Cost to arrive at the Maximum Reimbursable Cost (7x8/9) on line 10. The amount on line 10 is compared to the Total Cost from line 3 to calculate the schedule B-4 adjustment needed. (If line 10 is larger than line 3, then no adjustment is needed.)

Schedule B-1A



RECALCULATE
Press Button ONLY
AFTER Other Schedules
are Completed

Provider Name: Select ID first. (This is an automatic field.)
CALCULATION OF ANCILLARY COST ADJUSTMENTS
SCHEDULE B-1A

Provider No Select ID
6/30/2021

	Physical Therapy	Speech Therapy (PATH.)	Occup. Therapy	Therapy Rm Overhead (L&H)	Therapy Rm Overhead (O&M)	Therapy Rm Overhead (T&I)	Medical Supplies	Other Special	Radiology	DIETARY Tube Feeding
1. Total Costs Per Books (Schedule B-2, Column 6)	-	-	-	Therapy Room Overhead costs are calculated using Schedule B-5. The Total Charges and Medicaid Charges are calculated by totalling the amounts in Physical, Speech, and Occupational Therapy.			-	-	-	-
2. Schedule B-4 Adjustments	-	-	-				-	-	-	-
3. Total Costs	-	-	-	-	-	-	-	-	-	-
4. Total Charges (Schedule B-1, Column 1)	-	-	-	-	-	-	-	-	-	-
5. Ratio of Costs to Charges (Line 3 / Line 4)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000
6. Medicaid Charges (Schedule B-1, Column 2)	-	-	-	-	-	-	-	-	-	-
7. Medicaid Cost (Line 5 x Line 6)	-	-	-	-	-	-	-	-	-	-
8. Total Patient Days (Schd.A,Column 9,Line 13)	-	-	-	-	-	-	-	-	-	-
9. Medicaid Patient Days (Schd.A,Cols 4-6,Line 13)	-	-	-	-	-	-	-	-	-	-
10. Maximum Reimbursable Cos (line 7 x 8 / 9)	-	-	-	-	-	-	-	-	-	-
11. Enter the larger amount of Line 3 or Line 10	-	-	-	-	-	-	-	-	-	-
12. Schedule B-4 Adjustment (Line 10 - Line 11)	-	-	-	-	-	-	-	-	-	-

After you have completed filling out the cost report, you must come back to Sch. B-1A and press the recalculate button in the top left corner of the schedule. This generates the schedule B-4 adjustments.

Line 6 should include ONLY the Medicaid charges. Please keep a copy of the revenue journals used to generate these figures as they will be requested if the provider is selected for a field examination.

Schedule B-2

Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. Select ID
6/30/2021

1	2	3	4	5	6	7	8	9	10	11
Description (From Medicare Worksheet A)	Per Facility Books	Medicare Reclassifications (From Medicare Worksheet A-6)	Medicare Adjustments (From Medicare Worksheet A-8)	Medicare Cost Allocations (From Medicare Worksheet B, Part I)	Total Nursing Facility Amount (Sum columns 2 through 5)	New Capital Costs (From Medicare Worksheet B, Part II)	Total Nursing Facility Expense Net of Depreciation Allocation (Add Columns 6 and 7)	Adjustments to Expenses (Schedule B-4)	Medicare Cost Report Adjustments (Schedule B-8 Column 6)	As Adjusted Nursing Facility Allowable Expenses (Column 8 plus/ minus 9 and 10)
Routine Services:										
1. Nursing Facility	-				-		-	-	-	-
2. Nursing Administration	-				-		-	-	-	-
3. Nursing School	-				-		-	-	-	-
4. Intern Resident Service	-				-		-	-	-	-
4.a Employee Health & Welfare	-				-		-	-	-	-
5.					-		-	-	-	-
6. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 5)			(Schedule B, Column 4, Line 5)
Special Services:										
7. Social Services	-				-		-	-	-	-
8. Central Services	-				-		-	-	-	-
9. Pharmacy	-				-		-	-	-	-
10. Physician Care	-				-		-	-		-
10.a Physical Therapy	-				-		-	-		-
10.b Speech Therapy	-				-		-	-		-
10.c Oxygen Therapy	-				-		-	-		-
10.d Occupational Therapy	-				-		-	-		-
10.e Other Medical Supplies	-				-		-	-		-
10.f Recreational Activities	-				-		-	-		-
10.g Intravenous Therapy	-				-		-	-		-
10.h Other Special Services	-				-		-	-		-
10.i Radiology	-				-		-	-		-
11. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 6)			(Schedule B, Column 4, Line 6)

Columns and Layout:

Column 2 – This figure should tie to the direct costs reported on the nursing facilities general ledger.

Column 3 – Ties to Medicare CR, W/S A-6.

Column 4 – Ties to Medicare CR, W/S A-8.

The columns above are referred to as the ***DIRECT COSTS*** of the nursing facility.

Column 5 – Ties to Medicare W/S B, Part I.

Column 7 – Ties to Medicare W/S B, Part II (should be entered as negatives except for line 37). These entries reclassify capital expenses to the P&R cost center and should always net to $0.

Column 9 – Ties to Sch. B-4.

Column 10 – Ties to Sch. B-8 and represents adjustments made by the Medicare intermediary during PY audits and reviews.

Schedule B-2

Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. Select ID 6/30/2021

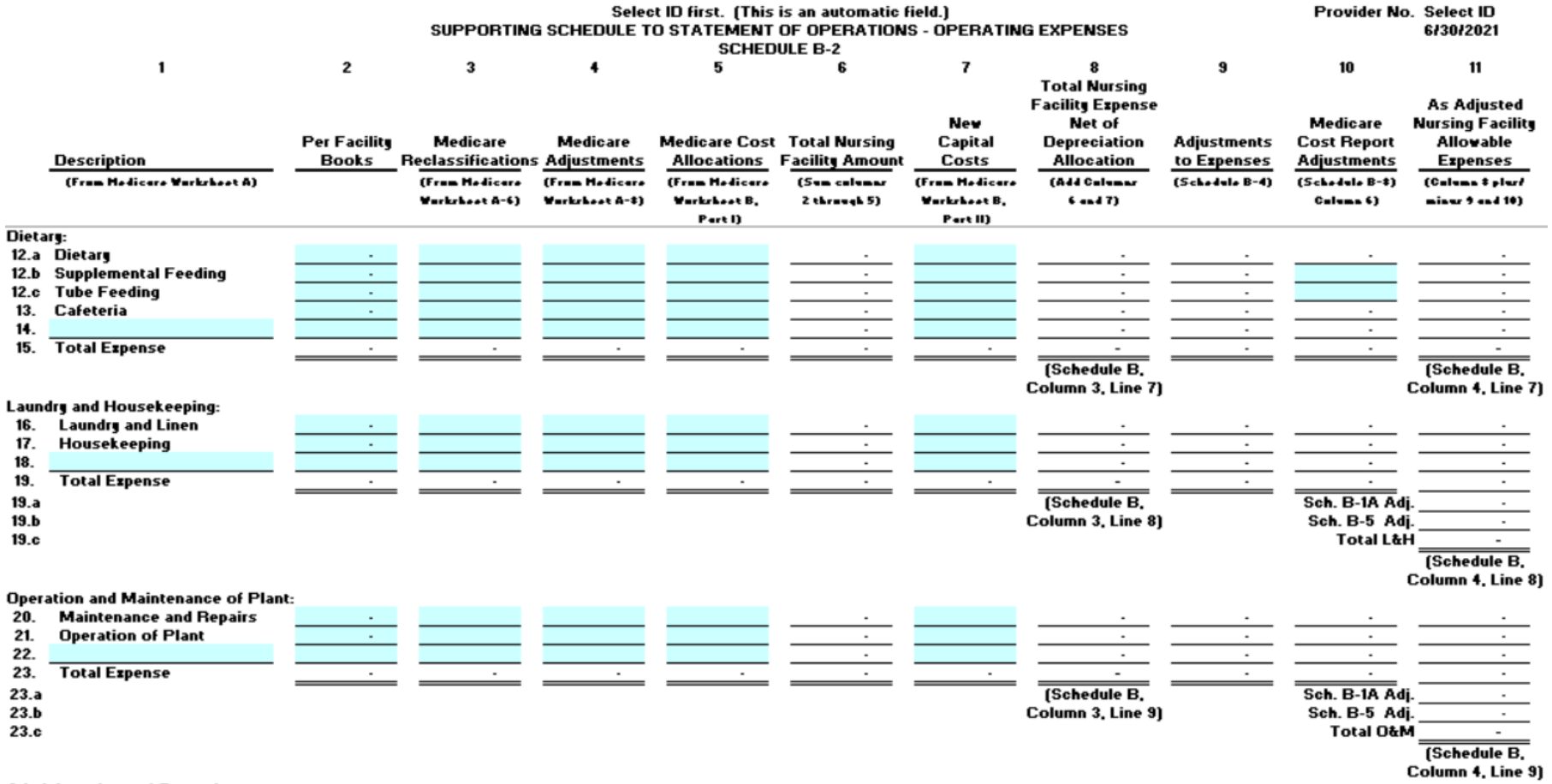
1	2	3	4	5	6	7	8	9	10	11
Description (From Medicare Worksheet A)	Per Facility Books	Medicare Reclassifications (From Medicare Worksheet A-6)	Medicare Adjustments (From Medicare Worksheet A-8)	Medicare Cost Allocations (From Medicare Worksheet B, Part I)	Total Nursing Facility Amount (Sum columns 2 through 5)	New Capital Costs (From Medicare Worksheet B, Part II)	Total Nursing Facility Expense Net of Depreciation Allocation (Add Columns 6 and 7)	Adjustments to Expenses (Schedule B-4)	Medicare Cost Report Adjustments (Schedule B-8) Column 6)	As Adjusted Nursing Facility Allowable Expenses (Column 8 plus/ minus 9 and 10)
Routine Services:										
1. Nursing Facility	-				-		-	-	-	-
2. Nursing Administration	-				-		-	-	-	-
3. Nursing School	-				-		-	-	-	-
4. Intern Resident Service	-				-		-	-	-	-
4.a Employee Health & Welfare	-				-		-	-	-	-
5.					-		-	-	-	-
6. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 5)			(Schedule B, Column 4, Line 5)
Special Services:										
7. Social Services	-				-		-	-	-	-
8. Central Services	-				-		-	-	-	-
9. Pharmacy	-				-		-	-	-	-
10. Physician Care	-				-		-	-		-
10.a Physical Therapy	-				-		-	-		-
10.b Speech Therapy	-				-		-	-		-
10.c Oxygen Therapy	-				-		-	-		-
10.d Occupational Therapy	-				-		-	-		-
10.e Other Medical Supplies	-				-		-	-		-
10.f Recreational Activities	-				-		-	-		-
10.g Intravenous Therapy	-				-		-	-		-
10.h Other Special Services	-				-		-	-		-
10.i Radiology	-				-		-	-		-
11. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 6)			(Schedule B, Column 4, Line 6)

Routine and Special Services are combined for rate setting purposes.

Lines 1-5 of Schedule B-2 are the Routine Service expenses. lines 7-10i are the Special Services expenses.

These costs should include all expenses. For example, row 1 will include all of the salaries, benefits, supplies, contracted services, etc. for routine services.

Schedule B-2



Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. Select ID
6/30/2021

1	2	3	4	5	6	7	8	9	10	11
Description (From Medicare Worksheet A)	Per Facility Books	Medicare Reclassifications (From Medicare Worksheet A-6)	Medicare Adjustments (From Medicare Worksheet A-8)	Medicare Cost Allocations (From Medicare Worksheet B, Part I)	Total Nursing Facility Amount (Sum columns 2 through 5)	New Capital Costs (From Medicare Worksheet B, Part II)	Total Nursing Facility Expense Net of Depreciation Allocation (Add Columns 6 and 7)	Adjustments to Expenses (Schedule B-4)	Medicare Cost Report Adjustments (Schedule B-8) Column 6)	As Adjusted Nursing Facility Allowable Expenses (Column 8 plus/ minus 9 and 10)
Dietary:										
12.a Dietary	-				-		-	-	-	-
12.b Supplemental Feeding	-				-		-	-		-
12.c Tube Feeding	-				-		-	-		-
13. Cafeteria	-				-		-	-	-	-
14.					-		-	-	-	-
15. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 7)			(Schedule B, Column 4, Line 7)
Laundry and Housekeeping:										
16. Laundry and Linen	-				-		-	-	-	-
17. Housekeeping	-				-		-	-	-	-
18.					-		-	-	-	-
19. Total Expense	-	-	-	-	-	-	-	-	-	-
19.a									Sch. B-1A Adj.	-
19.b									Sch. B-5 Adj.	-
19.c									Total L&H	-
							(Schedule B, Column 3, Line 8)			(Schedule B, Column 4, Line 8)
Operation and Maintenance of Plant:										
20. Maintenance and Repairs	-				-		-	-	-	-
21. Operation of Plant	-				-		-	-	-	-
22.					-		-	-	-	-
23. Total Expense	-	-	-	-	-	-	-	-	-	-
23.a									Sch. B-1A Adj.	-
23.b									Sch. B-5 Adj.	-
23.c									Total O&M	-
							(Schedule B, Column 3, Line 9)			(Schedule B, Column 4, Line 9)

Dietary expenses are included on lines 12.a – 14. ***NOTE:*** Tube feeding is a B-1A account that is recorded in dietary.

Laundry & Housekeeping (L&H) and Operation & Maintenance (O&M) are combined for rate setting purposes.

Lines 16 - 19 are the L&H Expenses. Line 19.b shows any adjustments coming from the Schedule B-5. Line 19.a shows any adjustments coming from the Schedule B-1A.

Lines 20 – 22 are the O&M Expenses. Line 23.b shows any adjustments coming from the Schedule B-5. Line 23.a shows any adjustments coming from the Schedule B-1A.

Schedule B-2

Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. Select ID 6/30/2021

1	2	3	4	5	6	7	8	9	10	11
Description (From Medicare Worksheet A)	Per Facility Books	Medicare Reclassifications (From Medicare Worksheet A-6)	Medicare Adjustments (From Medicare Worksheet A-8)	Medicare Cost Allocations (From Medicare Worksheet B, Part I)	Total Nursing Facility Amount (Sum columns 2 through 5)	New Capital Costs (From Medicare Worksheet B, Part II)	Total Nursing Facility Expense Net of Depreciation Allocation (Add Columns 6 and 7)	Adjustments to Expenses (Schedule B-4)	Medicare Cost Report Adjustments (Schedule B-8 Column 6)	As Adjusted Nursing Facility Allowable Expenses (Column 8 plus/ minus 9 and 10)
Administrative and General:										
24. Data Processing	-				-		-	-	-	-
25. Purchasing	-				-		-	-	-	-
26. Admitting	-				-		-	-	-	-
27. Collections	-				-		-	-	-	-
28. Administration & General	-				-		-	-	-	-
29. Medical Records	-				-		-	-	-	-
30. Maintenance of Personnel	-				-		-	-	-	-
31. Nursing Aide Training/Testing	-				-		-	-	-	-
32. Provider Fee	-				-		-	-	-	-
33.					-		-	-	-	-
34. Total Expense	-	-	-	-	-	-	-	-	-	-
							(Schedule B, Column 3, Line 10)			(Schedule B, Column 4, Line 10)

DETAIL OF NURSE AIDE TRAINING AND TESTING EXPENSE

Salaries and Wages		Contracted Services	
Employee Benefits and Payroll Taxes		Equipment	
Supplies		Other Costs	
Travel			

Total Nurse Aide Testing Costs: - (Col. 6, Line 31)

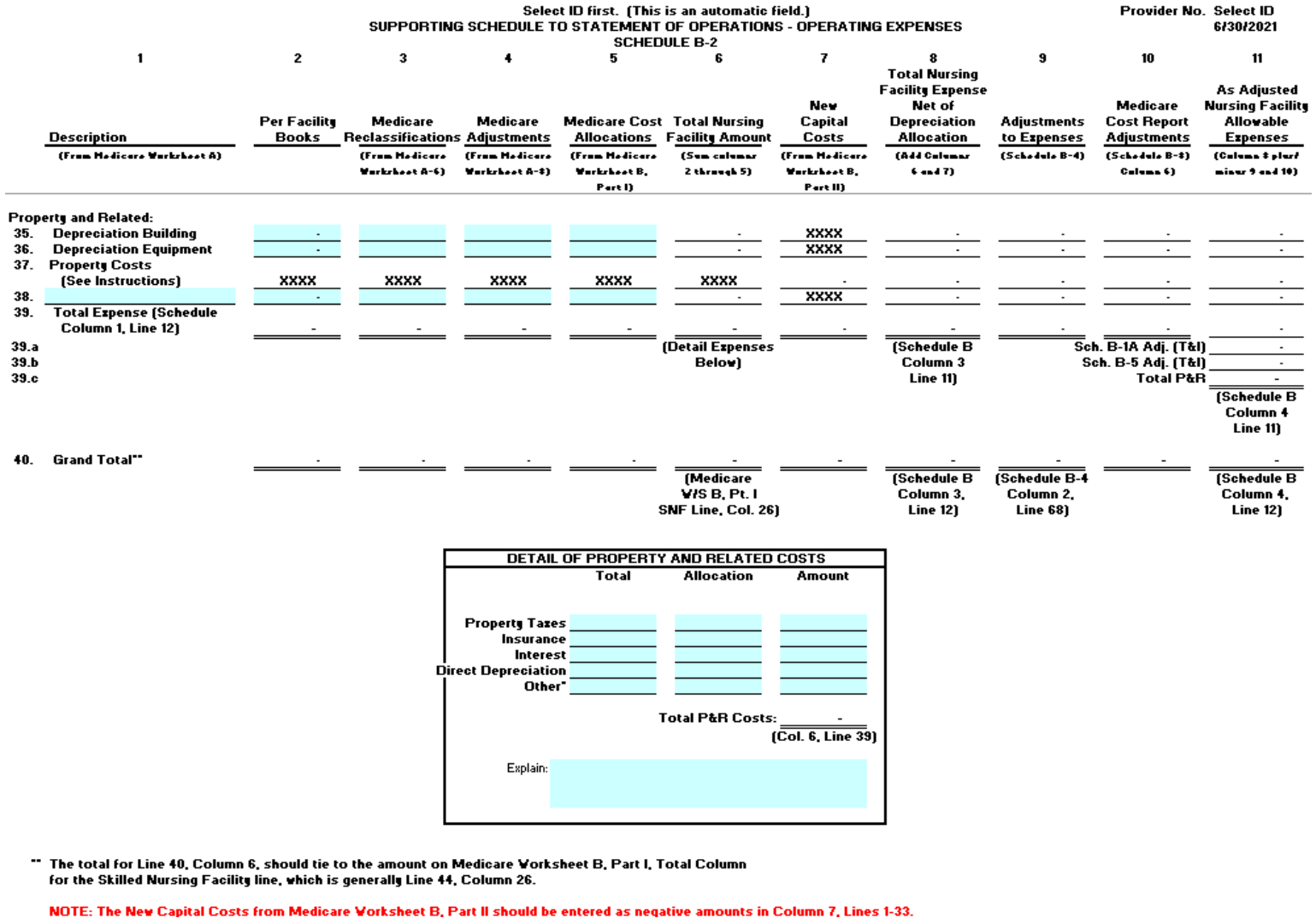
Lines 24 - 33 are the Administrative & General (A&G) expenses.

The provider fee is excluded from A&G expenses when calculating the rate of the cost center.

The Nurse Aide Training and Testing (NATT) expenses listed on line 31 should be removed and reported in the detail box. The as adjusted amount in Column 11 ***should always be $0*** for NATT expenses.

The NATT should be detailed in the area provided. These expenses are reimbursed dollar for dollar by DCH and are not included in the A&G rate calculation.

Schedule B-2



Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. | Select ID 6/30/2021

1	2	3	4	5	6	7	8	9	10	11
Description (From Medicare Worksheet A)	Per Facility Books	Medicare Reclassifications (From Medicare Worksheet A-6)	Medicare Adjustments (From Medicare Worksheet A-8)	Medicare Cost Allocations (From Medicare Worksheet B, Part I)	Total Nursing Facility Amount (Sum columns 2 through 5)	New Capital Costs (From Medicare Worksheet B, Part II)	Total Nursing Facility Expense Net of Depreciation Allocation (Add Columns 6 and 7)	Adjustments to Expenses (Schedule B-4)	Medicare Cost Report Adjustments (Schedule B-8) Column 6)	As Adjusted Nursing Facility Allowable Expenses (Column 8 plus/ minus 9 and 10)
Property and Related:										
35. Depreciation Building	-				-	XXXX	-	-	-	-
36. Depreciation Equipment	-				-	XXXX	-	-	-	-
37. Property Costs (See Instructions)	XXXX	XXXX	XXXX	XXXX	XXXX	-	-	-	-	-
38.	-				-	XXXX	-	-	-	-
39. Total Expense (Schedule Column 1, Line 12)	-	-	-	-	-	-	-	-	-	-
39.a					(Detail Expenses Below)		(Schedule B Column 3 Line 11)		Sch. B-1A Adj. (T&I)	-
39.b									Sch. B-5 Adj. (T&I)	-
39.c									Total P&R	-
										(Schedule B Column 4 Line 11)
40. Grand Total**	-	-	-	-	-	-	-	-	-	-
					(Medicare W/S B, Pt. I SNF Line, Col. 26)		(Schedule B Column 3, Line 12)	(Schedule B-4 Column 2, Line 68)		(Schedule B Column 4, Line 12)

DETAIL OF PROPERTY AND RELATED COSTS

	Total	Allocation	Amount
Property Taxes			
Insurance			
Interest			
Direct Depreciation			
Other*			

Total P&R Costs: - (Col. 6, Line 39)

Explain:

** The total for Line 40, Column 6, should tie to the amount on Medicare Worksheet B, Part I, Total Column for the Skilled Nursing Facility line, which is generally Line 44, Column 26.

NOTE: The New Capital Costs from Medicare Worksheet B, Part II should be entered as negative amounts in Column 7, Lines 1-33.

Lines 35 - 38 of Schedule B-2 are the Property & Related (P&R) and Taxes and Insurance (T&I) expenses.

The provider is required to detail out the expenses between the P&R and T&I in the detail box.

P&R expenses are reimbursed through Fair Rental Value System.

T&I expenses are reimbursed dollar-for-dollar.

Line 39.b should tie to Schedule B-5.

Line 39.s should tie to Schedule B-1A.

Line 40, Column 6 should tie to the amount reported on Medicare W/S B, Part I, SNF Line (usually line 44), Column 26. ***If these amounts do not match, the cost report will not be accepted and the provider will be asked to refile.***

Schedule B-3

Schedule B-3, Part I details Other Operating Revenues.

If any of the other revenues listed have an associated expense, that expense should be removed up to the revenue received.

The provider may remove these expenses by making either a Sch. B-4 adjustment or a Medicare W/S A-8 adjustment.

Provider No. Select ID

Provider Name: Select ID first. (This is an automatic field.) 6/30/2021

SUPPORTING SCHEDULES TO STATEMENT OF OPERATIONS
OTHER REVENUES AND NON-OPERATING EXPENSES

SCHEDULE B-3

Part I - Other Revenues

	Account No.		Balance Per Books	Amount Offset on Medicare A-8
		OTHER OPERATING REVENUE		
1.	465.00	Employee Housing	-	-
2.	466.00	Purchasing Services	-	-
3.	467.00	Parking	-	-
4.	468.00	Housekeeping Services	-	-
5.	469.00	Data Processing Services	-	-
6.	470.00	Sale of Abstracts/Medical Records	-	-
7.	471.00	Sale of Scrap and Waste	-	-
8.	472.00	Rebates and Refunds	-	-
9.	473.00	Vending Machine Commissions	-	-
10.	474.00	Other Commissions	-	-
11.	475.00	Employee and Guest Meals (Cafeteria Sales)	-	-
12.	478.00	Donated and Federal Surplus Commodities	-	-
13.	480.00	Television and Cable	-	-
14.	482.00	Laundry and Linen Services	-	-
15.	483.00	Telephone	-	-
16.	484.00	Activities Program (Social Services)	-	-
17.	491.00	Non-patient Room Rentals	-	-
18.	496.00	Management Service Fees	-	-
19.	497.00	Cash Discounts Earned on Purchases	-	-
20.	499.00	Other Operating Revenues (See Analysis Required Below)	-	-
21.		TOTAL OTHER OPERATING REVENUES	-	-

ANALYSIS OF OTHER OPERATING REVENUE
(ACCOUNT NO. 499.00)
All amounts that exceed $1,000 should be itemized by activity type.

	Description		
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.	TOTAL (Must agree with total of Line 20)	-	-

Schedule B-3

Schedule B-3, Part I lines 30 - 39 document other non-operating revenues and may require similar offsets.

Schedule B-3, Part I line 41 should tie to Schedule B.

Schedule B-3, Part I lines 42-48 should tie to line 39 for Other Operating Revenue. Please note that “miscellaneous” or “prior year” is not a sufficient description. The description should be detailed enough to be able to determine the source of the revenue.

Provider No. Select ID
6/30/2021

Provider Name: Select ID first. (This is an automatic field.)
SUPPORTING SCHEDULES TO STATEMENT OF OPERATIONS
OTHER REVENUES AND NON-OPERATING EXPENSES

SCHEDULE B-3

Part I - Other Revenues

	Account No.		Balance Per Books	Amount Offset on Medicare A-8
		NON-OPERATING REVENUES		
30.	476.00	Grants, Endowments, and Trusts (Unrestricted Contributions)	-	-
31.	477.00	Donated Services	-	-
32.	481.00	Beauty and Barber Shop Revenue	-	-
33.	486.00	Personal Purchases	-	-
34.	487.00	Sales - Canteen and Gift Shop	-	-
35.	488.00	Uniform Sales	-	-
36.	490.00	Office and Other Rental Revenue	-	-
37.	492.00	Interest Income, Gains and Losses from Unrestricted Investments	-	-
38.	495.00	Gain or Loss on Sale of Assets	-	-
39.	498.00	Other Non-operating Revenue (See Analysis Required Below)	-	-
40.		TOTAL NON-OPERATING REVENUES	-	-
41.		TOTAL OTHER REVENUES (Total of Lines 21 and 40 must agree with Schedule B, Line 14)	-	-

ANALYSIS OF OTHER NON-OPERATING REVENUE
(ACCOUNT NO. 498.00)
All amounts that exceed $1,000 should be itemized by activity type.

	Description		
42.			
43.			
44.			
45.			
46.			
47.			
48.			
49.	TOTAL (Must agree with total of Line 39)	-	-

Schedule B-3

Schedule B-3, Part II line 58 should tie to Schedule B.

*The section includes expenses that are not reimbursable and are not included on schedule B-2.

Provider No. Select ID

Provider Name: Select ID first. (This is an automatic field.) 6/30/2021

SUPPORTING SCHEDULES TO STATEMENT OF OPERATIONS
OTHER REVENUES AND NON-OPERATING EXPENSES

SCHEDULE B-3

Part I - Other Revenues

	Account No.		Balance Per Books	Amount Offset on Medicare A-8

Part II - Non-Operating Expenses

Note: This section is for non-operating expenses that have not been included in Schedule B-2.

	Account No.		Balance Per Books	Amount Offset on Medicare A-8
50.	960.00	Canteen and Gift Shop	-	-
51.	965.00	Rental (Sub-lease,etc.)	-	-
52.	970.00	Utilization Review Expense/Medical Care Review	-	-
53.				
54.				
55.				
56.				
57.				
58.	TOTAL NON-OPERATING EXPENSE (SCHEDULE B, LINE 15)		-	-

Schedule B-4

Provider Name: Select ID first. (This is an automatic field.)
ADJUSTMENTS TO EXPENSES
SCHEDULE B-4

Provider No. Select ID
6/30/2021

ADD ROW | DELETE ROW

	1	2	3	4
	Basis*	Amount**	Schedule B-2 Line No. (Instructions)	Clarifying Comments
1. Television, Cable and Telephone				
2. Life Insurance premium				
3. Sale of meals to other than patients				
4. Vending machines				
5.a Prescription drugs				
5.b Non-Emergency Transportation				
5.c Laboratory				
6. Sale of drugs and supplies to other than patients				
7. Sale of scrap, waste, etc.				
8. Purchase discounts				
9. Rebates and refunds				
10. Bad debts				
11. Interest income on unrestricted funds				
12. Recovery of insured loss				
13. Physician's medical services				
14. Depreciation - non-patient care				
15. Excessive depreciation				
16. Excessive advertising				
17. Gain or loss on sale of assets				
18. Personal expenses-other				
19. Cost of lodging rented or provided owners/employees				
20. Interest expense-nonpatient care related				
21. Related party-				
22. Rent				
23. Contracted Services				
24. Allocated Expenses				
25. Interest				
26. Supplies				
27. Depreciation				
27. Tax penalties				
28. Donations and contributions				
29. Stock registration expense				
30. Stockholder meetings				
31. Excess directors' fees				
32. Excess compensation				
33. Franchise fees				

Column 1 allows the nursing home to indicate the basis for the amount of the adjustment. Basis A indicates an adjustment was based on expenses and basis B indicates the adjustment was made based on revenues.

Column 3 should tie to the corresponding line of schedule B-2 where the adjustment hits.

Column 4 allows the nursing home to add clarifying comments.

Schedule B-4

34. Amortization of goodwill				
35. Fund raising expenses				
36. Disposal expenses of nonpatient care assets				
37. Nonreimbursable travel, including convention and education				
38. Sub-lease rental offset				
39. Restricted grants and gifts offset				
40. Nurse Aide Training and Testing		-		
41. Physical Therapy		-	10.a	Schedule B-1A, Line 12
43. Speech Therapy (Pathology)		-	10.b	Schedule B-1A, Line 12
44. Occupational Therapy		-	10.d	Schedule B-1A, Line 12
45. Therapy Room Overhead (L&H)		-	19.a	Schedule B-1A, Line 12
46. Therapy Room Overhead (O&M)		-	23.a	Schedule B-1A, Line 12
47. Therapy Room Overhead (T&I)		-	39.a	Schedule B-1A, Line 12
48. Medical Supplies		-	10.e	Schedule B-1A, Line 12
49. Other Special Services		-	10.h	Schedule B-1A, Line 12
50. Radiology		-	10.i	Schedule B-1A, Line 12
51.				
52. Tube Feeding		-	12.c	Schedule B-1A, Line 12
53. Cost of Ancillary Services Furnished by Hospital				Supplemental Schedule Required
54.				
55.				
56. Indirect Expense Allocation (L&H)		-	19.b	Schedule B-5, Line 12
57. Indirect Expense Allocation (O&M)		-	23.b	Schedule B-5, Line 12
58. Indirect Expense Allocation (T&I)		-	39.b	Schedule B-5, Line 12
59.				
60.				
61.				
62.				
63.				
64.				
65.				
66.				
67.				
68. Total Adjustments		-		

*The amounts entered 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.
**Adjustments which will decrease per book expenses should be shown in parenthesis.

Additional Notes:

Lines 41 - 51 should tie to Schedule B-1A.

Lines 56 - 58 should tie to Schedule B-5.

Schedule B-5

Provider Name: Select ID first. (This is an automatic field.) Provider No: Select ID 6/30/2021

ALLOCATION OF INDIRECT EXPENSES TO NON-PATIENT CARE AREAS
SCHEDULE B-5

	1 Square Feet/ % of Total	1.a Pounds of Laundry/ % of Total (optional)	2 Laundry	2.a Housekeeping	3 Operation and Maintenance of Plant	4 Property Taxes and Insurance
1. Total Expenses, as Adjusted, Before Allocation of Indirect Expenses		INSTRUCTIONS: If you wish to use pounds of laundry for the laundry distribution, click the "Use Pounds" box and use column 1a IN ADDITION TO	- (Schedule B-2,	- Line 19, Col. 11	- (Schedule B-2, Line 23, Col. 11)	- (Schedule B-2, Line 39, Col. 11)
ALLOCATION OF COSTS						
Non-Patient Care-			☐ Use Pounds			
2. Gift Shop	/ 0.00%	/ 0.00%	-	-	-	-
3. Rental (Sub-Lease, etc.)	/ 0.00%	/ 0.00%	-	-	-	-
4. Other (Describe)						
5.	/ 0.00%	/ 0.00%	-	-	-	-
6.	/ 0.00%	/ 0.00%	-	-	-	-
7.	/ 0.00%	/ 0.00%	-	-	-	-
8.	/ 0.00%	/ 0.00%	-	-	-	-
9.	/ 0.00%	/ 0.00%	-	-	-	-
10.	/ 0.00%	/ 0.00%	-	-	-	-
11.	/ 0.00%	/ 0.00%	-	-	-	-
12. Subtotal (Sum of Lines 2 Through 11)	- / 0.00%	- / 0.00%	- (Schedule B-2, Line 19.b)	- (Schedule B-2, Line 19.b)	- (Schedule B-2, Line 23.b)	- (Schedule B-2, Line 39.b)
12a. Therapy Room	/ 0.00%	/ 0.00%	-	-	-	-
13. Patient Care (Nursing Facility and Special Care)	/ 0.00%	/ 0.00%	-	-	-	-
14. Total (Sum of Lines 12 through 13 and Should Agree With Line 1)	- / 100.00%	- / 100.00%	-	-	-	-

NOTE: All providers must complete this schedule, line 12a and line 13 are required. Additionally, total facility square footage should include all patient care related areas that meet all of the following criteria:
1. Fully Enclosed
2. Heated or Cooled
3. Constructed of similar material as the nursing facility
4. Located on the same campus as the nursing facility

Therapy Room overhead should flow to Schedule B-1A.

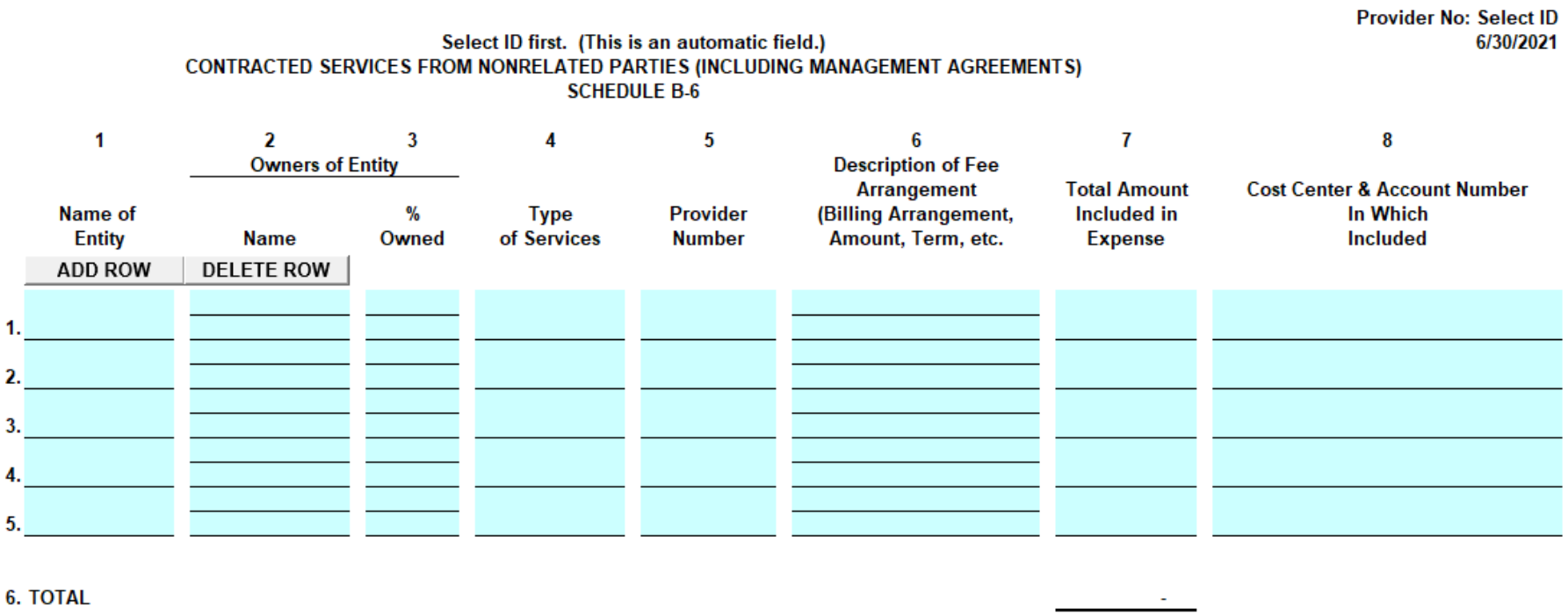
Column 1 is used to enter the square footage for all areas of the nursing home, with the percentages automatically calculated based on what is entered.

Column 1a is an optional method of allocating Laundry expense if the nursing home tracks laundry by poundage, if the provider tracks laundry this way please check the “Use Pounds” option.

Columns 2-5 includes all indirect cost areas to be allocated. Any areas of the nursing home considered non-patient care related are include on lines 2-11.

Note: If non-patient care square footage is included on Schedule B-5, the adjustments on line 12 should flow to schedule B-4 and schedule B-2.

Schedule B-6



Provider No: Select ID
6/30/2021

Select ID first. (This is an automatic field.)
CONTRACTED SERVICES FROM NONRELATED PARTIES (INCLUDING MANAGEMENT AGREEMENTS)
SCHEDULE B-6

	1	2	3	4	5	6	7	8
		Owners of Entity						
	Name of Entity	Name	% Owned	Type of Services	Provider Number	Description of Fee Arrangement (Billing Arrangement, Amount, Term, etc.	Total Amount Included in Expense	Cost Center & Account Number In Which Included
	ADD ROW	DELETE ROW						
1.								
2.								
3.								
4.								
5.								
6. TOTAL							-	

Please Note:
--List all contracts of $100 or more per month, or $1200 or more per annum.
--Include owner's name (Column 2) and equity information (Column 3) for all contracted entities with less than five owners.
--If the contractor participates in the Georgia Medicaid Program, list their Provider Number in Column 5.

This schedule should include only the contracts that are included in the direct costs of the SNF, those amounts included on the SNF line of Medicare W/S A.

Column 1 should list specific vendor names. Various is not an adequate description.

Column 4 should include the type of service the vendor performs.

Column 7 should include the entire expense from the vendor.

Column 8 should include the cost center and account number the expense is included on.

If this schedule is not completed, it will be requested by Myers and Stauffer during the review/examination.

Schedule B-7

Schedule B-7 should only be completed if the provider has ventilator services. All costs associated with the vent program should be removed from schedule B-2.

The vent unit square footage should be included on schedule B-5.

The provider should include ventilator patient days.

Provider No. Select ID
6/30/2021

Provider Name: Select ID first. (This is an automatic field.)
VENTILATOR SERVICES PROGRAM COST SUMMARY
OTHER REVENUES AND NON-OPERATING EXPENSES
SCHEDULE B-7

Direct and Indirect Ventilator Services Summary

	Routine Services	Special Services	Dietary	Laundry & Housekeeping*	Operations & Maintenance*	Taxes & Insurance*	Total Costs
DIRECT COSTS							
Salaries & Wages							-
Benefits & PR Taxes							-
Contract Services							-
Supplies							-
Equipment							-
Other Costs							-
TOTAL DIRECT COSTS*	-	-	-	-	-	-	-
INDIRECT COSTS							
Vent Program Indirect Costs (Schedule B-5)							-
TOTAL COSTS*	-	-	-	-	-	-	-

* Adjustment should be made on Schedule B-2 to remove costs associated with the Ventilator Services Program.

Ventilator Services Patient Day Summary

Payor Source	On-site	Hospital/Leave Days	Total Patient Days
Medicare			-
Medicaid			-
Other			-
Total Ventilator Patient Days	-	-	-

Schedule B-8

Schedule B-8 calculates the impact of the adjustments made by the Medicare fiscal intermediary during their reviews. Any Medicare cost report that has been final settled must be submitted with the Medicaid cost report.

Note: If the provider had multiple cost reports settled, please click the button in the upper left corner.

Click Here if Multiple Medicare Cost Reports were Settled

Provider No. Select ID

Provider Name: Select ID first. (This is an automatic field.) 6/30/2021

COMPARISONS OF FINAL SETTLED MEDICARE COST REPORT TO ORIGINAL FILING

FINAL SETTLEMENT YEAR

Please Put Settlement Year Here

SCHEDULE B-8

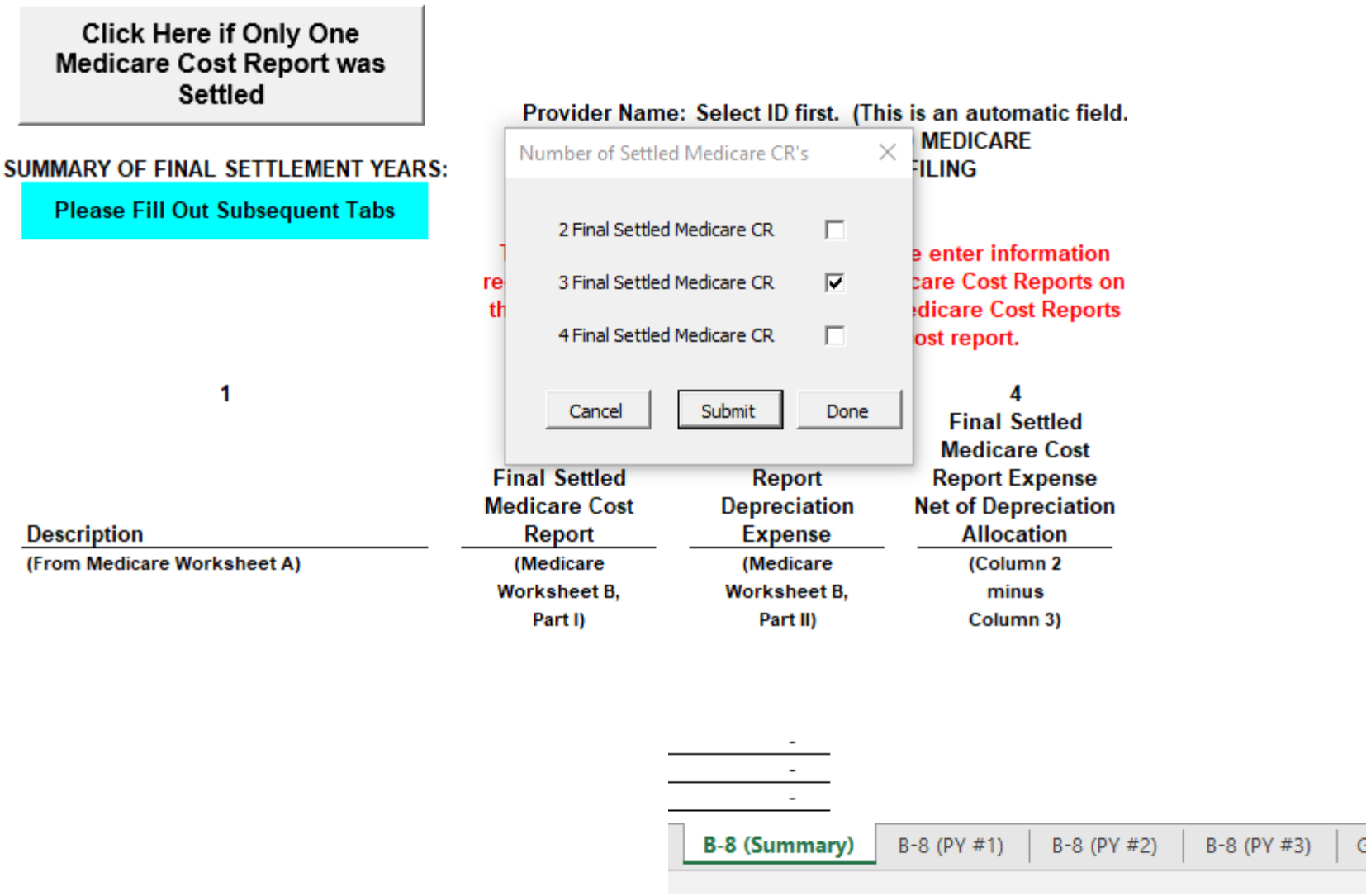
	1	2	3	4	5	6
	Description (From Medicare Worksheet A)	Final Settled Medicare Cost Report (Medicare Worksheet B, Part I)	Final Settled Medicare Cost Report Depreciation Expense (Medicare Worksheet B, Part II)	Final Settled Medicare Cost Report Expense Net of Depreciation Allocation (Column 2 minus Column 3)	Original Medicare Cost Report Net of Capital Cost Allocation (Appropriate Prior Year Medicaid Worksheet B-2)	Differences (Column 2 minus Column 3) (Schedule B-2, Column 7)
	Routine Services:					
1.	Nursing Facility			-		-
2.	Nursing Administration			-		-
3.	Nursing School			-		-
4.	Intern Resident Service			-		-
4.a	Employee Health & Welfare			-		-
5.				-		-
6.	Total Expense	-	-	-	-	-
	Special Services:					
7.	Social Services			-		-
8.	Central Services			-		-
9.	Pharmacy			-		-
10.				-		-
11.	Total Expense	-	-	-	-	-
	Dietary:					
12.	Dietary			-		-
13.	Cafeteria			-		-
14.				-		-
15.	Total Expense	-	-	-	-	-

Schedule B-8

After selecting the macro button, a pop-up will appear asking how many final settled cost reports the provider has, please select the appropriate selection and click submit.

After clicking submit, a tab for each final settled cost report year will appear. Then click done and the pop-up will close.

Fill the PY tabs out, as described in the next few slides and the summary tab will automatically populate with the totals.



Schedule B-8

Column 2 – Comes from the Medicare ***FINAL SETTLED*** cost report, W/S B, Part I.

Column 3 - Comes from the Medicare ***FINAL SETTLED*** cost report, W/S B, Part II. This amount should be entered as a negative, as is done on schedule B-2. Line 37 of schedule B-8 will automatically calculate the positive reclassification to P&R.

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED
OMB NO. 0938-0050
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY [redacted]

Period: From 7/1/2015 To 6/30/2016

Worksheet S
Parts I-III
Date/Time Prepared:
7/23/2018 2:22 am

PART I - COST REPORT STATUS

Provider use only
1. [X] Electronically filed cost report — Date: — Time:
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only
5. [2] Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Reopened
(5) Amended
6. Date Received: 10/18/2016
7. Contractor No. 10001
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date: 06/20/2018
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS [redacted]

Period: From 7/1/2015 To 6/30/2016

Worksheet B
Part I
Date/Time Prepared:
7/23/2018 2:22 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	[redacted]					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS						30.00
31.00	03100 INTENSIVE CARE UNIT						31.00
44.00	04400 SKILLED NURSING FACILITY	150,000					44.00

Health Financial Systems [redacted] In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS [redacted]

Period: From 7/1/2015 To 6/30/2016

Worksheet B
Part II
Date/Time Prepared:
7/23/2018 2:22 am

	Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DIETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	[redacted]					30.00
31.00	03100 INTENSIVE CARE UNIT						31.00
44.00	04400 SKILLED NURSING FACILITY	500					44.00

Click Here if Multiple Medicare Cost Reports were Settled

Provider Name: Select ID first. (This is an automatic field.) Provider No. Select ID
COMPARISONS OF FINAL SETTLED MEDICARE COST REPORT TO ORIGINAL FILING 6/30/2021

FINAL SETTLEMENT YEAR
6/30/2016

SCHEDULE B-8

The Final Settled Medicare Cost Report for 6/30/2016 must be submitted with this cost report.

1	2	3	4	5	6
Description (From Medicare Worksheet A)	Final Settled Medicare Cost Report (Medicare Worksheet B, Part I)	Final Settled Medicare Cost Report Depreciation Expense (Medicare Worksheet B, Part II)	Final Settled Medicare Cost Report Expense Net of Depreciation Allocation (Column 2 minus Column 3)	Original Medicare Cost Report Net of Capital Cost Allocation (Appropriate Prior Year Medicaid Worksheet B-2)	Differences (Column 2 minus Column 3) (Schedule B-2, Column 7)
Operation and Maintenance of Plant:					
20. Maintenance and Repairs	150,000	(500)	149,500		149,500
21. Operation of Plant			-		-

Schedule B-8

Provider Name:
SUPPORTING SCHEDULE TO STATEMENT OF OPERATING EXPENSES
SUPPLEMENTAL SCHEDULE TO SCHEDULE B-2

Provider No. 6/30/2016

	Operating Expenses Description	1 Per Facility Books	2 Medicare W\S A-6	3 Medicare W\S A-8	4 Medicare Cost Allocations Worksheet B	5 Total Cost (W\S B L. 34 COL, 27)
Laundry & Housekeeping:						
16	Laundry & Linen	-				-
17	Housekeeping	-				-
18						-
19	Total Expense	-	-	-	-	-
Operations & Maintenance:						
20	Maintenance & Repairs	86,000			148,000	234,000
21	Operations of Plant					-
22						-
23	Total Expense	86,000	-	-	148,000	234,000

SUPPORTING SCHEDULE TO STATEMENT OF OPERATIONS - OPERATING EXPENSES
SCHEDULE B-2

Provider No. 6/30/2016

	Description (From Medicare Worksheet A)	1 Total NF or ICF-ID Amount (See Instructions)	2 New Capital Costs From Medicare Worksheet B, Part II)	3 Total NF or ICF-ID Expense Net of Depreciation Allocation (Add Columns 2,3,and 4)	4 Adjustments to Expenses (Schedule B-4)	5 Medicare Cost Report Adjustments (Schedule B-7) Column 6)	6 As Adjusted NF or ICF-ID Allowable Expenses Column 5 plus/ minus 6 and 7)
Laundry and Housekeeping:							
16.	Laundry and Linen	-		-	-	-	-
17.	Housekeeping	-		-	-	-	-
18.		-		-	-	-	-
19.	Total Expense	-	-	-	-	-	-
19.a				(Schedule B, Column 3, Line 9)		Sch. B-1a Adj.	-
19.b						Sch. B-5 Adj.	-
19.c						Total L&H	-
							(Schedule B, Column 4, Line 9)
Operation and Maintenance of Plant:							
20.	Maintenance and Repairs	234,000	(485)	233,515	-	-	233,515
21.	Operation of Plant	-		-	-	-	-
22.		-		-	-	-	-
23.	Total Expense	234,000	(485)	233,515	-	-	233,515
23.a				(Schedule B, Column 3, Line 10)		Sch. B-1a Adj.	-
23.b						Sch. B-5 Adj.	-
23.c						Total O&M	233,515
							(Schedule B,

+	148,000
-	485
2	147,515

Click Here if Multiple Medicare Cost Reports were Settled

Provider Name: Select ID first. (This is an automatic field.)
COMPARISONS OF FINAL SETTLED MEDICARE COST REPORT TO ORIGINAL FILING

Provider No. Select ID 6/30/2021

FINAL SETTLEMENT YEAR 6/30/2016

SCHEDULE B-8

The Final Settled Medicare Cost Report for 6/30/2016 must be submitted with this cost report.

	Description (From Medicare Worksheet A)	1	2 Final Settled Medicare Cost Report (Medicare Worksheet B, Part I)	3 Final Settled Medicare Cost Report Depreciation Expense (Medicare Worksheet B, Part II)	4 Final Settled Medicare Cost Report Expense Net of Depreciation Allocation (Column 2 minus Column 3)	5 Original Medicare Cost Report Net of Capital Cost Allocation (Appropriate Prior Year Medicaid Worksheet B-2)	6 Differences (Column 2 minus Column 3) (Schedule B-2, Column 7)
Operation and Maintenance of Plant:							
20.	Maintenance and Repairs		150,000	(500)	149,500	147,515	1,985
21.	Operation of Plant				-		-
20.					-		-
23.	Total Expense		150,000	(500)	149,500	147,515	1,985

Column 5 – Comes from the ***ORIGINAL*** Medicaid cost report, schedule B-2.

Depending on the year of the final settled Medicare cost report, you may need to use both the supplemental B-2 and schedule B-2 in order to calculate the amount.

Column 6 – Calculates the difference and that amount will automatically populate column 10 on schedule B-2.

Schedule G

Provider Name: Select ID first. (This is an automatic field.)

Provider No: Select ID
6/30/2021

NURSING HOURS AND EMPLOYEE BENEFITS SUMMARY
SCHEDULE G

Part I: Nursing Hours Summary

	1 Position	2 Total Hours	3 Employee Hours	4 Contractor Hours
1. RN		-	-	-
2. LPN		-	-	-
3. CNA		-	-	-
4. Other		-	-	-
4. Total		-	-	-

Part II: Employee Benefits Summary

	1 Total	2 Routine & Special Services	4 Dietary	5 Laundry & Housekeeping and Operations & Maintenance	7 Administrative & General	8 NATT
Worker's Compensation	-					
Payroll Taxes	-					
Life Insurance	-					
Group Health Insurance	-					
Retirement Plan	-					
Profit Sharing Plan	-					
Other	-					
Total	-	-	-	-	-	-

Schedule G should detail out the nursing hours by position and break them down between employee and contractor hours.

Additionally, Schedule G should detail out the employee benefits that are included on the cost report and show which cost centers they are recorded in.

Schedule G-1

Provider Name: Select ID first. (This is an automatic field.)

Provider No: Select ID
6/30/2021

FACILITY STAFFING COST SUMMARY
ANNUALIZED COMPENSATION IN EXCESS OF $56,447
SCHEDULE G-1

	1	2	3	4	5	6	7	8	9	10
	Name	Position / Title	Cost Center	Year Ended June 30 Compensation*	Year Ended June 30 Hours Paid*	Other Comp Not In Salaries	Retirement/ Pension Costs	Non-Allowable Job Duties	% of Time Spent on Non-Allowable Duties	Sch B-2 Line # Included
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.		Dietary Supervisor								
9.		Social Worker								
10.		Maintenance Director								
11.		Admissions Director								
12.		Clinical Liaison								
13.		Business Office Manager								
14.										
15.										
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.										
27.										
28.										
29.										
30.										

NOTE: The specific positions listed in column 2 and ALL individuals who perform job duties designed to increase patient utilization of the facility MUST be listed above regardless of relationship and compensation thresholds.

*Place (*) next to individuals with portions of salary cost and/or hours at other facilities or Non-Medicaid (Attach detailed worksheet).

This schedule should include employees who are owners or non-owner related parties.

All employees with an hourly wage in excess of $27.14 must also be listed.

Schedule G-1 should list all employees earning more than 54,696/yr. or $26.30/hr. This schedule should only include those employees who are included on the SNF line of the Medicare cost report W/S A.

This schedule should also list out all employees with positions that are in white, regardless of their compensation.

Compare the employee's title in column 2 to the cost center reported in column 3 to ensure the provider properly classified all employees.

Schedule G-1

Provider Name: Select ID first. (This is an automatic field.)

Provider No: Select ID
6/30/2021

FACILITY STAFFING COST SUMMARY
ANNUALIZED COMPENSATION IN EXCESS OF $56,447
SCHEDULE G-1

	1	2	3	4	5	6	7	8	9	10
	Name	Position / Title	Cost Center	Year Ended June 30 Compensation*	Year Ended June 30 Hours Paid*	Other Comp Not In Salaries	Retirement/ Pension Costs	Non-Allowable Job Duties	% of Time Spent on Non-Allowable Duties	Sch B-2 Line # Included
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.		Dietary Supervisor								
9.		Social Worker								
10.		Maintenance Director								
11.		Admissions Director								
12.		Clinical Liaison								
13.		Business Office Manager								
14.										
15.										
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.										
27.										
28.										
29.										
30.										

NOTE: The specific positions listed in column 2 and ALL individuals who perform job duties designed to increase patient utilization of the facility MUST be listed above regardless of relationship and compensation thresholds.

*Place (*) next to individuals with portions of salary cost and/or hours at other facilities or Non-Medicaid (Attach detailed worksheet).

This schedule should include employees who are owners or non-owner related parties.

All employees with an hourly wage in excess of $27.14 must also be listed.

Common Employee Misclassifications:

- *Staff Development belongs in A&G*
- *Supply Clerk belongs in A&G*
- *Marketing is not allowable*
  - *Any position who spends a portion of their time doing marketing should have the non-allowable portion noted in column 9 and an adjustment made on schedule B-4 to remove the expense.*

If an employee splits their time between the hospital and the SNF, please keep the time studies or documentation used to support the allocation, as it could be requested by Myers and Stauffer.

Schedule H

Things to note:

Part 1 – The provider should list all of the related parties and list their provider number and the services they provide.

Part 2 – The provider should list 100% of the ownership of the nursing facility.

Provider No. Select ID
6/30/2021

Provider Name: Select ID first. (This is an automatic field.)
STATEMENT OF RELATED PARTY INFORMATION
SCHEDULE H

1 List All Related Parties and Provide the Information Indicated.

	1	2	3	4	5	6	7	8	9
			Owner(s) of Entity					List Related Party Participation in Other Medicaid Program Service and Provide Provider Number	
	Related Party	Provider Number	Name	% Owned	Type Service	Medicare Schedule A-8-1 Line Number	Amount	Type Service	Provider Number
1.									
2.									
3.									
4.									
5.									
6.									
7.									

Please Note:
--Include owner's name (Column 3) and equity information (Column 4) for all related party entities.
--If the related party is an individual, repeat the name from Column 1 in Column 3.

2 Provide the Following Information About the Ownership of the Provider:

	1	2	3	4	5	6	7
		Owner(s) of Entity		Name and Provider Number of Other Nursing Homes in Which Owner or His Relatives Have Interest		List Owner Participation in Other Medicaid Program Service and Provide Provider Number	
	Name (Individual, Corporation or Partnership) And % Owned	Name	% Owned	Name	Provider Number	Type Service	Provider Number
8.							
9.							
10.							
11.							
12.							
13.							
14. TOTAL			0%				

100% OWNERSHIP OF THE PROVIDER MUST BE LISTED

Things to note:

Part 3 – The provider should list any administrators and anyone receiving directors fees. They should also list any individual who would be considered a related party.

Schedule H

3 List Administrators, Assistant Administrators and all employees or officers who (1) receive compensation and (2) are owners or relatives of an owner, the Administrator or Assistant Administrator. In addition, list all Directors and their compensation.

	1	2	3	4	5	6	7	8
	ADD ROW / DELETE ROW							
	Name	Title	Relationship to Owner, Administrator or Assistant Administrator	Number of Hours Worked Per Week	Total Compensation Included in Medicare Worksheet A	Total Directors Fees	Number of Meetings	Total Other Compensation Not Included In Medicare Worksheet A
15.								
16.								
17.								
21.								
19.								
20.								

21. TOTAL -

Please Note:
--Other compensation should include payments for personal use of auto, lodging or any other benefits not included in total compensation.

22. Additional clarifying comments, if needed:

Questionnaire

Provider Name: Select ID first. (This is an automatic field.)
NURSING HOME COST REPORT UNDER TITLE XIX
GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE
HOSPITAL BASED NURSING FACILITY PROVIDERS

QUESTIONNAIRE AND CHECKLIST
PERIOD ENDED 6/30/2021
(To be filed with cost report.)

Note that an explanation must be provided for any "NO" answer-see space provided at the end of the checklist. The designation N/A should be utilized if the question is not applicable.

Schedule A		Yes	No
1.	Inpatient days and occupancy data have been accurately compiled from the census records of the facility, and include hospital and leave days that have been reimbursed from any source.		
2.	The number of beds agrees with that certified by the Licensure Unit of DHR.		

General		Yes	No
3.	Is the Medicare cost report submitted, the same cost report filed with the Medicare intermediary?		
4.	Have any other Medicare cost reports been final settled since the prior year Medicaid cost report was filed (or any Medicare cost report settled where adjustments affecting the Nursing Facility have not been flowed through a Medicaid cost report)?		
5.	If the answer to Question 4 is "yes", have applicable adjustments been reflected in this Medicare cost report on Schedule B-8?		
6.	List the years of all open Medicare cost reports not final settled.		

Provider No.: Select ID
6/30/2021

Note: All no answers should be sufficiently explained in the provided space beneath question 16.

General		Yes	No	Date Submitted
7.	Has the Nursing Facility received allocations from all cost centers in the Medicare cost report? If the answer is "no", provide a detailed supporting explanation of the allocation approach used.			
8.	Has an analysis of fund balances been completed, if the provider filed cost reports for years which are different than its year-ends, in conformance with the instructions to the cost report?			
9.A	Has the facility completed a Fair Rental Value Project(s) in accordance with Appendix D(6) of the Nursing Facility Services Procedure Manual?			
9.B	Initial Startup and FRVS Update Request Form Submitted:			

Note: This section should detail all open Medicare cost reports that have not been settled.

Questionnaire

10.A Self Insurance

Are you self-insured for any type of coverage?

If yes, please answer parts i and ii below.

i. What type of coverage is self-insured?

ii. Are you claiming in allowable costs:

1. contributions to the fund?
2. actual claims paid out of the fund?

*If you chose both 1 and 2, explain here:

10.B Captive Insurance

Are you using a captive insurance for any type of coverage? Yes / No

If yes, what type of coverage is insured by the captive?

11. If leasing the facility, please list the following:

1. Beginning date of lease
2. Ending date of lease
3. Amount of lease

12. Itemize the dues portion paid by or on the behalf of the nursing home:

Add Row | Delete Row

Name of Organization	Purpose	Amount Paid	Hospital Cost On CMS 2552, Worksheet A, Line ========:	Direct Cost of Nursing Home on Schedule B-2, Line=====:

13. Are any property taxes directly expensed by the Nursing Facility: Yes / No

Add Row | Delete Row

Payee	Property Type	Amount Paid	Direct Costs Sch. B-2 Ln:

Accrued Prop. Tax Amt. for the NF: $ -

Please provide the accrual amount and describe the method for calculating accrued property taxes:

14. Are any Insurance policies directly expensed by the Nursing Facility: Yes / No

Add Row | Delete Row

Insurance Company	Policy Type	Amount Paid	Direct Costs Sch. B-2 Ln:

Ending Prepaid Ins. for the NF: $ -

Please provide the ending accrual amount and describe the method for calculating prepaid insurance:

Note: If the provider answers “yes” to 13 or 14 then they should provide additional information.

Questionnaire

10.A Self Insurance

Are you self-insured for any type of coverage?

If yes, please answer parts i and ii below.

i. What type of coverage is self-insured?

ii. Are you claiming in allowable costs:

1. contributions to the fund?
2. actual claims paid out of the fund?

*If you chose both 1 and 2, explain here:

10.B Captive Insurance

Are you using a captive insurance for any type of coverage? Yes / No

If yes, what type of coverage is insured by the captive?

11. If leasing the facility, please list the following:

1. Beginning date of lease
2. Ending date of lease
3. Amount of lease

12. Itemize the dues portion paid by or on the behalf of the nursing home:

Add Row | Delete Row

Name of Organization	Purpose	Amount Paid	Hospital Cost On CMS 2552, Worksheet A, Line ========:	Direct Cost of Nursing Home on Schedule B-2, Line=====:

13. Are any property taxes directly expensed by the Nursing Facility: Yes / No

Add Row | Delete Row

Payee	Property Type	Amount Paid	Direct Costs Sch. B-2 Ln:

Accrued Prop. Tax Amt. for the NF: $ -

Please provide the accrual amount and describe the method for calculating accrued property taxes:

14. Are any Insurance policies directly expensed by the Nursing Facility: Yes / No

Add Row | Delete Row

Insurance Company	Policy Type	Amount Paid	Direct Costs Sch. B-2 Ln:

Ending Prepaid Ins. for the NF: $ -

Please provide the ending accrual amount and describe the method for calculating prepaid insurance:

Note: If the provider answers “yes” to 13 or 14 then they should provide additional information.

A worksheet detailing the prepaid taxes or insurance should be submitted as an attachment to the cost report.

Questionnaire

15. Period Ending 6/30/2021 General and Professional Liability Expense
Complete the questions below for the General and Professional Liability expenses incurred in this period.

A. Please specify the reporting period if it is a portion of the 7/1/2020 to 6/30/2021 reporting period:

B. GL/PL insurance reported on Medicare Cost Report, W/S S-2, Part 1, Line 118.01

1. GL/PL insurance expense from W/S S-2, Part 1, Line 118.01:
2. Percent Allocated to the Nursing Home:
3. GL/PL insurance included in the step down allocation to the nursing home: - (1X2)
4. GL/PL insurance directly expensed to the nursing home:
5. Total GL/PL insurance amount allocated and directly expensed: - (3+4)

C. GL/PL insurance amount on Medicare Cost Report, W/S S-2, Part 1, Line 118.02:

1. GL/PL insurance expense from W/S S-2, Part 1, Line 118.02:
2. Percent Allocated to the Nursing Home:
3. GL/PL insurance included in the step down allocation to the nursing home: - (1X2)
4. GL/PL insurance directly expensed to the nursing home:
5. Total GL/PL insurance amount allocated and directly expensed: - (3+4)
6. Allocation basis used for Line 118.02 costs:
7. Cost centers these costs are included in:

D. Total GL/PL Insurance expense included on the Medicaid Cost Report: - (B5+C5)

E. Total patient days reported on Medicaid Cost Report Sch. A, Line 13, Column 9: -

F. Type of GL/PL Insurance - Place an "X" in all that apply:
Self Insurance Trust
Captive Insurance
Commercial Insurance
Other - Describe

16. Total Patient Trust funds held by the nursing facility:

COMMENTS ON "NO" ANSWERS (Except for questions 10, 13 and 14)

Question No.	COMMENTS

For FY2021, the GL/PL information has been incorporated into the cost report questionnaire.

The GL/PL amounts listed here should be able to be reconciled to the Medicare cost report, W/S S-2. Any insurance amounts directly expensed to the SNF should be supported by a policy or an internal worksheet from the provider. All documentation regarding the GL/PL amount should be submitted with the cost report.

Any questions that were answered “no” to should be further explained in this section.

QUESTIONS

MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS