

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT INSTRUCTIONS

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
FISCAL ADMINISTRATION PROVIDER AUDIT
SFN 941 (Rev. 06-16)

GENERAL INFORMATION

The cost report schedules and other data required on the cost report provides the cost basis for the the determination of rates to be paid to psychiatric residential treatment facilities. The data required conforms to the requirements set forth in North Dakota Administrative Code Chapter 75-02-09 Ratesetting for Psychiatric Residential Treatment Facilities.

Cost data reported must be in conformity with NDAC 75-02-09. The grouping of accounts for rate setting purposes can be satisfied when trial balance amounts are recorded on Schedule C-4.

In addition to cost reporting, the following information should be considered in the completion of the forms and for general information:

1. Only those costs that affect resident care and are allowable under Chapter 75-02-09 will be included as Psychiatric Residential Treatment Facility (PRTF) costs. PRTF costs that are unallowable include, but are not limited to, fundraising costs and in-house education costs.
2. On all schedules and reports please report only whole dollars.
3. Round all percentages to two (2) decimal places, i.e. 69.53%.
4. All information submitted is subject to audit by Department of Human Services staff.
5. Revised schedules SFN 941 (Rev. 06-16) must be used and all schedules must be returned with the cost report.
6. The report is due at the Provider Audit Unit on or before the last day of the third month following the facility's report year. In the event that the facility fails to file the cost report on or before the due date, a penalty for late filing may be assessed.

If further detailed information is required, reference should be made to the Department of Human Services, NDAC 75-02-09 or contact:

Medical Services Division
600 E. Boulevard Avenue
Bismarck, ND 58505-0261
Ph: 701.328.2321 www.nd.gov/dhs

CHECKLIST FOR PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT

The checklist should be completed and returned with all other schedules to Provider Audit. The address is as follows:

Fiscal Administration Provider Audit
1600 E. Century Avenue Suite 5
Bismarck, ND 58503
Ph: 701.328.7560 www.nd.gov/dhs

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SCHEDULE A

Schedule A is used for the completion of general, licensing and occupancy information plus an administrator's and preparer's certification.

SCHEDULE A-1

Schedule A-1 is used to report the rate charged during the report period for residents that are private pay or whose payments are made by other states or other public pay programs rather than the North Dakota medical services program.

SCHEDULE B-1

Schedule B-1 is used to report the number of resident days by type, i.e. in-house or hospital, on a monthly basis by licensed section.

SCHEDULE B-2

Schedule B-2 is used to report the number of resident days on a monthly basis. Total days must agree to Schedule B-1, Line 23. Schedule B-2 is used to report all days billed. Include all children, even if payment was received from sources other than state medical assistance.

SCHEDULES C

Schedules C-1 through C-8 are used to report cost and revenue information. Schedules C-1, C-4, C-5, C-5a, C-6, C-7 and C-8 are to be completed by all facilities. Schedules C-2 and C-3 are to be completed by a combination facility or a facility with non-psychiatric residential treatment related activities. Schedule C-4 identifies costs by cost center and by line item. Direct non-psychiatric residential treatment related costs must be entered in the Non-PRTF column. The amounts on Schedule C-4 are to be used to enter data on Schedule C-1.

SCHEDULE C-1

Schedule C-1 is used to summarize the adjustments reported on Schedule D and for the allocation of costs using data as appropriate from Schedules C-2 and C-3. Facilities who are not required to complete Schedules C-2 or C-3 should complete only the first three columns of Schedule C-1. All other facilities must complete the entire schedule. The allocation method column is to be completed identifying the method number from Schedules C-2 or C-3. The amounts for PRTF, RCCF, and Other are to be calculated using the percentages from Schedules C-2 or C-3.

Non-psychiatric residential treatment costs reported on Schedule C-4 may be summarized into administration and all other non-PRTF costs line under non-PRTF costs only if these costs are not allocated in their respective cost categories on Schedule C-1.

SCHEDULE C-2

Schedule C-2 is to be completed by a facility that can directly identify costs within a cost center in which costs will also be allocated between psychiatric residential treatment and non-psychiatric residential treatment. A separate Schedule C-2 is to be completed for each cost center component if a cost center is to be partially direct costed and partially allocated. Direct costs are

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SCHEDULE C-2 (con't)

first identified and included as PRTF, RCCF and Other. The remaining costs are then allocated based on the allocation percentages for the appropriate method reported on Schedule C-3. If the costs are allocated based on the methodology set forth in Section 7, Cost Allocations, of NDAC, Chapter 75-02-09.; this schedule is not necessary.

For the purpose of cost reporting, cost category means the classification or grouping of similar or related costs and the determination of cost limitations and rates. The cost categories are administration, direct care, dietary, laundry, plant and housekeeping, property and non-psychiatric residential treatment. For the purpose of cost reporting, cost components are salaries and fringe benefits, other costs, and property.

SCHEDULE C-3

Schedule C-3 is used to report statistical data that will be used to allocate costs for a combination facility, or a facility with non-psychiatric residential treatment related activities. The other column is to be used for non-psychiatric residential treatment related activities. Detailed work papers supporting the facility's accumulation of the statistical data must be submitted if any calculations were necessary to accumulate the data, i.e., property allocation which is first allocated to a cost center by square footage and then allocated by the methodology that applies to that particular cost center.

SCHEDULE C-4

Schedule C-4 is used to report facility cost information. If account totals do not trace directly from the trial balance to Schedule C-4, a separate work paper (lead schedule) identifying the account names and amounts that were grouped together, along with the total that ties to C-4, must be submitted.

SCHEDULE C-5

Schedule C-5 is used to report information on fringe benefits. Where the facility directly assigns fringe benefits, the amounts should be entered in the direct column. Fringe benefits not directly assigned will be allocated to the various cost centers based on the percent of salaries to the total salaries. Amounts identified in the total column by cost center are to be used on Schedule C-4.

SCHEDULE C-5a

Schedule C-5a is used to report the employees name, salary paid and whether the salary cost is administration, direct care, dietary, laundry, plant and housekeeping, or non-psychiatric residential treatment.

SCHEDULE C-6

Schedule C-6 is used for a reconciliation between the total expenses recorded on the financial statements and the total costs reported on Schedule C-4, Line 29.

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SCHEDULE C-7

Schedule C-7 is used to identify revenue by general ledger account number. A trial balance that lists all revenue accounts by account number, name, and amount may be submitted in lieu of Schedule C-7.

SCHEDULE C-8

Schedule C-8 is used for a reconciliation between total revenue from Schedule C-7 to total financial statement revenue.

SCHEDULE D

Schedule D is a summary of adjustments to costs that are identified on Schedules D-1 through D-4. This schedule identifies adjustments required under various sections of the North Dakota Administrative Code. Use a separate column on Schedule D for each adjustment reported on Schedules D-1 through D-4. While we have attempted to identify most of the required adjustments, preparers should use the administrative code to determine if additional adjustments should be made. The total adjustments are to be reported on Schedule C in the facility adjustment column.

SCHEDULE D-1 to D-4

Schedules D-1 to D-4 are used to record adjustments under the cost center and cost component directly affected. It may be necessary to allocate the adjustments to salaries, fringes, and other costs when no direct relationship exists. Schedule D-1 to D-4 will have to be completed prior to completing Schedule D, Summary of Adjustments to Costs.

SCHEDULE D-5

Schedule D-5 is used to provide information on specific areas which may require adjustment on Schedules D-1 through D-4.

SCHEDULE D-6

Schedule D-6 is used for the adjustment of dues, contributions and advertising costs that are unallowable per NDAC 75-02-09, Section 8. Provide the detail accounts for dues, contribution, and advertising with this schedule.

SCHEDULE E

Schedule E is used to provide information on Home Office costs. This schedule must be completed by a facility who has claimed costs for a home office or a parent organization. A summary of the home office costs, adjustments made, and allocation to the related providers must be submitted with the cost report.

SCHEDULE F

Schedule F is used to summarize interest income and identify interest income to be offset on Schedule D-4.

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SCHEDULE G

Schedule G is completed for each individual who can be included in one of the categories listed on the schedule in accordance with NDAC 75-02-09, Section 15.

SCHEDULE H

Schedules H are used for reporting costs of ownership of a facility leased or rented from a related party (Schedule H-1) and for information on the related party organization (Schedule H-2).

SCHEDULE I

Schedules I are used to report organizational information on the facility operators (Schedule I-1) and facility owners (Schedule I-2).

SCHEDULE J

Schedule J is used to report information on the assets and related depreciation expense of the facility.

SCHEDULE K

Schedule K is used to report information on debt and interest expense claimed by the facility. Identify working capital, workers compensation and vendor interest expense.

SCHEDULE L

Schedule L is used to report information on lease or rental of building and equipment from non-related parties.

SCHEDULE M

Schedule M is used for information on special rates established under NDAC 75-02-09-04.4. This schedule may be completed if a special rate is requested by the facility for facilities that have an increase in licensed capacity by twenty percent or more or have renovation or construction projects in excess of fifty thousand dollars, or an increase in costs to add services or staff.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT - CHECKLIST

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Facility	
Reporting Period	To:
From:	

DESCRIPTION		Schedule Provided	Substitute Schedule	Not Applicable
A	General Information and Certification			
A-1	Private Pay Fees and Charges			
B-1	Census Data			
B-2	Resident Census			
C-1	Cost Summary and Allocation			
C-2	Allocation for Cost Center Component with Direct Costs			
C-3	Statistical Data			
C-4	Statement of Facility Cost			
C-5	Fringe Benefits			
C-5a	Salaries			
C-6	Cost Reconciliation			
C-7	Revenues			
C-8	Revenue Reconciliation			
D	Summary of Adjustments to Costs			
D-1	Adjustments to Costs			
D-2	Adjustments to Costs			
D-3	Adjustments to Costs			
D-4	Adjustments to Costs			
D-5	Top Management Compensation			
D-6	Adjustment Questionnaire			
D-7	Dues, Contributions, Memberships and Advertising Adjustment			
E	Summary of Home Office Costs			
F	Interest Income			
G	Compensation Category			
H-1	Related Party Lease of Rental of Building or Equipment			
H-2	Related Party Information			
I-1	Report of Psychiatric Residential Treatment Facility Owner			
I-2	Report of Psychiatric Residential Treatment Facility Operator			
J	Depreciation			
K	Interest			
L	Lease or Rental Information			
M	Special Rates			

PLEASE RETURN THIS AND ALL OTHER SCHEDULES

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT - SCHEDULE A/GENERAL INFORMATION AND CERTIFICATION

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Name of Facility		Date	
Street Address		City	Zip Code
Telephone Number	FAX Number	Provider Number	E-Mail Address
Name of Administrator		Reporting Period From:	To:
INTENTIONAL MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.			

LICENSE TYPE	TOTAL LICENSED NUMBER OF BEDS
TOTAL	

STATISTICAL DATA	
TOTAL PRTF DAYS	
1. Licensed PRTF beds	
2. Days Available (Line 1 X 365 or 366)	
3. Total available days (Line 1 X Line 2)	
4. Percent of Occupancy	

ADMINISTRATOR'S CERTIFICATION	
I Certify That I Have Examined This Psychiatric Residential Treatment Facility Cost Report In Its Entirety And To The Best Of My Knowledge It Is A True And Correct Statement Prepared From The Accounts And Records Of This Institution Consistent With NDAC 75-02-09.	
Date	Signature of Administrator

ACCOUNTANT'S CERTIFICATION	
I Certify That I Am Independent Of This Facility And Have Examined This Psychiatric Residential Treatment Facility Cost Report In Its Entirety And Have Found The Cost Report Information To Be In Compliance With NDAC 75-02-09 And The Cost Finding Principles And Processes Applied On a Basis Consistent With That Of The Prior Year.	
Date	Signature of Preparer or Firm

PROVIDER AUDIT USE ONLY	
Computer File Number	
Audit Report Number	
Input Date	
Input Initials	

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE A-1/
PRIVATE PAY FEES AND CHARGES**

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Facility	
Reporting Period	
From:	To:

Rates charged to private pay or other public pay residents.	Period Covered		
Payor Type i.e. private pay, State of Minnesota	RATE	FROM	TO

North Dakota Psychiatric Residential Treatment Rates			
Maintenance Rate	RATE	FROM	TO

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE B-2/RESIDENT CENSUS

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Facility	
Reporting Period	
From:	To:

Name of Resident	Total Days	MONTH											
1													
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21													
22													
23													
24													
25													
26													
27													
28													
29													
30													
31													
32													
33													
TOTAL													

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE C-1/COST SUMMARY AND ALLOCATION

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Facility	
Reporting Period	
From:	To:

	Total Costs	Facility Adjustments	Adjusted Costs	Allocation Method	PRTF	RCCF	Other
Allocable Administration							
Salaries							
Fringe Benefits							
Other Costs							
Direct PRTF Administration							
Salaries							
Fringe Benefits							
Other Costs							
Direct Care							
Salaries							
Fringe Benefits							
Other Costs							
Dietary							
Salaries							
Fringe Benefits							
Other Costs							
Laundry							
Salaries							
Fringe Benefits							
Other Costs							
Plant and Housekeeping							
Salaries							
Fringe Benefits							
Utilities							
Other Costs							
PROPERTY COSTS							
NON-PRTF							
Administration							
All Other Non-PRTF Costs							
TOTAL COSTS							

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE C-2/ALLOCATION FOR COST CENTER COMPONENT WITH IDENTIFIED DIRECT COSTS

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Facility	
Reporting Period	
From:	To:

NOTE: This form must be used when the facility's record of original entry directly identifies costs to non psychiatric residential treatment care.				
Cost Center:				
Cost Component:				
Direct Costs:	TOTAL	PRTF	RCCF	OTHER
Allocated Costs:				
Allocation Method No:	0.00%			
Total Costs 1)				
ADJUSTMENTS TO COSTS:				
Direct Adjustments:				
Allocated Adjustments:				
Allocation Method No:	0.00%			
Total Adjustments				
Total Adjusted Costs 2)				

A separate Schedule C-2 must be completed for each cost component of each cost center being direct costed on the facility's records. Cost components are, for example, salaries, fringe benefits, other costs. Cost centers are, for example, administration, direct costs, dietary, laundry, plant and housekeeping, and property.

Direct costs are first identified from the facility's records and entered above to psychiatric residential treatment facilities, residential child care facilities, or other services, then the remaining costs reported on Schedule C-4 are allocated using the appropriate allocation method.

- 1) Total costs must equal total costs on Schedule C-4.
- 2) Total adjusted costs are reported on Schedule C-1.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE C-3/STATISTICAL DATA

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Facility	
Reporting Period	
From:	To:

NOTE: This form must be completed for facilities allocating costs on Schedule C-1.

METHOD NUMBER	ITEM	TOTAL	PRTF	RCCF	OTHER
1.	Direct Care Salaries (Must be direct costed)				
2.	Meals Served				
3.	Weighted Square Footage				
4.	Pounds of Laundry				
5.	Resident Days				
6.	In-House Resident Days				
7.	Vehicle Mileage Logs				
8.	Total Costs Less Allocable Administration				
9.					
10.	Property Attach workpaper detailing allocation				
11.	* Other				
12.	* Other				
13.	* Other				
14.	* Other				
15.	* Other				
16.	* Other				
17.	* Other				
18.	* Other				

* Identify

** Round percentages to 2 decimal places, i.e. 10.47%.

DUPLICATE AS NECESSARY

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE D/SUMMARY OF ADJUSTMENTS TO COST ON SCHEDULES D-1 THRU D-4

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Facility	
Reporting Period	
From:	To:

	Total	ADJUSTMENTS						
		1	2	3	4	5	6	7
Allocable Administration								
Salaries								
Fringe Benefits								
Other Costs								
Direct PRTF Administration								
Salaries								
Fringe Benefits								
Other Costs								
Direct Care								
Salaries								
Fringe Benefits								
Other Costs								
Dietary								
Salaries								
Fringe Benefits								
Other Costs								
Laundry								
Salaries								
Fringe Benefits								
Other Costs								
Plant and Housekeeping								
Salaries								
Fringe Benefits								
Utilities								
Other Costs								
PROPERTY COSTS								
NON-PRTF								
Administration								
All Other Non-PRTF Costs								
TOTAL ADJUSTMENTS TO COSTS								

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE D/SUMMARY OF ADJUSTMENTS TO COST ON SCHEDULES D-1 THRU D-4

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Facility	
Reporting Period	
From:	To:

	ADJUSTMENTS CONTINUED							
	8	9	10	11	12	13	14	15
Allocable Administration								
Salaries								
Fringe Benefits								
Other Costs								
Direct PRTF Administration								
Salaries								
Fringe Benefits								
Other Costs								
Direct Care								
Salaries								
Fringe Benefits								
Other Costs								
Dietary								
Salaries								
Fringe Benefits								
Other Costs								
Laundry								
Salaries								
Fringe Benefits								
Other Costs								
Plant and Housekeeping								
Salaries								
Fringe Benefits								
Utilities								
Other Costs								
PROPERTY COSTS								
NON-PRTF								
Administration								
All Other Non-PRTF Costs								
TOTAL ADJUSTMENTS TO COSTS								

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE D-5/
WORKSHEET FOR TOP MANAGEMENT PERSONNEL COMPENSATION**

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Facility	
Reporting Period	To:
From:	

1. Individual:	Title:	AMOUNT
a. Salary for all services		
b. Personal benefit payments, i.e. housing, flat rate automobile		
c. Cost of assets and services received from facility		
d. Pension, annuities, and deferred compensation		
e. Value of supplies or services provided by the facility		
f. Cost of a domestic or other employee who works in the individual's home		
g. Health insurance		
h. Life insurance		
i. Other (IDENTIFY)		
2. Total Compensation		
3. Less Adjustments by Facility on Schedule D: (enter as negative numbers)		
a. Pension		
b. Other (IDENTIFY)		
4. Total Compensation Less Adjustments (Line 2 minus Lines 3.a & 3.b)		

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE D-5/
ADJUSTMENT QUESTIONNAIRE**

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Facility	
Reporting Period	To:
From:	

		YES	NO
1.	Have costs for transportation of residents been included in the cost report?		
2.	Have costs for staff travel been included in the cost report?		
3.	Has documentation been prepared and maintained to establish the purpose of travel and that it is resident related?		
4.	What is the facility's policy for reimbursement of travel? NOTE: Travel costs in excess of the amounts		
5.	Are mileage logs maintained showing beginning and ending odometer readings, destination and purpose of trip? NOTE: All vehicle costs not supported by mileage logs, in excess of the amounts established by the Internal Revenue Service and vehicle costs not related to resident care must be offset on Schedule D-2.		
6.	Have costs for fees paid to members of board of directors been offset on Schedule D-1?		
7.	What is the facility's policy for reimbursement of director fees?		
8.	Does the facility offer fringe benefits to all employees? If yes, is the payment structure the same for all employees?		
9.	Have utilization records been kept on a daily basis or usage basis for equipment used in non-psychiatric residential treatment?		

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE D-6/WORKSHEET FOR DUES, CONTRIBUTIONS, MEMBERSHIPS, AND ADVERTISING ADJUSTMENT

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Facility	
Reporting Period	
From:	To:

Costs Reported on Schedule C-4: List all general ledger accounts and amounts for dues, contributions, memberships, sponsorships and advertising.

ACCOUNT	AMOUNT

Review detail of the above accounts and reclassify into the following cost categories:		
	ALLOWABLE	UNALLOW-ABLE
1. Dues		
Dues		
License fees		
Subscriptions		
2. Contributions		
Political contributions		
Community contributions		
Charitable donation		
3. Memberships		
Sports, health, fraternal, social		
Other		
4. Advertising		
Recruitment advertising		
Promotional advertising		
Other		
5. Other costs		
6. TOTAL		
7. Total costs (Line 6)		
8. Unallowable costs		
9. Dues, contributions, memberships and advertising adjustment (Line 7 - Line 8)		
10. Dues adjustment (Sum of Line 1)		
11. Contributions or charitable donations adjustment (Sum of Line 2)		
12. Memberships adjustment (Sum of Line 3)		
13. Advertising adjustment (Sum of Line 4)		
14. Other costs adjustment (Line 5)		

PLEASE PROVIDE DUES, CONTRIBUTIONS AND ADVERTISING ACCOUNT DETAIL

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE F/
INTEREST INCOME**

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Facility	
Reporting Period	
From:	To:

NOTE: This form must be completed if interest income has been earned and interest expense has been claimed.

OFFSETS		
ACCOUNT	DESCRIPTION	AMOUNT
SUB-TOTAL TO SCHEDULE D-4		

OTHER INTEREST INCOME NOT OFFSET		
ACCOUNT	DESCRIPTION	AMOUNT
SUB-TOTAL		

Total interest income for the period (must equal the general ledger) _____

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE G/
COMPENSATION CATEGORY**

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Facility	
Reporting Period From:	To:

- | | |
|--------------------------|--|
| 1. Sole Proprietor | 4. Member of a Governing Board or Group |
| 2. Partner | 5. Family members of top management personnel as defined by NDAC 75-02-09-15. |
| 3. Corporate Stockholder | 6. Individual having an ownership in or is an officer of any related organization. |

Complete the following information below for any individual or employee who received compensation and qualified for one of the compensation categories listed above.

Name: TYPES OF SERVICE PERFORMED	Annual Hours Worked		
	No. of Hours *	Hourly Salary **	Amount
TOTAL			

Total Salary Amount Above		
Housing Allowance		
Flat Rate Automobile Allowance		
Cost of Assets and Services Received		
Housing		
Automobile		
Other		
Deferred Compensation, Pension, Annuity		
Supplies and Services Received for Personal Use		
Cost of a Domestic/Other Employee Works in the Individual's Home		
Life and Health Insurance Premiums		
Other (Itemize)		
Less salary and fringe adjustments on cost report (identify)		
Total compensation less adjustments		
Percent of compensation allocated to facility		
TOTAL amount allocated to facility		

*DOCUMENTATION MUST BE AVAILABLE TO INDICATE THE TYPES OF SERVICES PERFORMED AND THE NUMBER OF HOURS WORKED BY MONTH AND DAY.
**INDICATE BASIS OF VALUATION.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE H-1/RELATED PARTY LEASE OR RENTAL OF BUILDING OR EQUIPMENT

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Facility	
Reporting Period From:	To:

Related Party Name: _____

Lease or Rental charges claimed as costs \$ _____

Allowable Cost of Ownership
(Provide supporting documentation and schedules for indicated costs).

Property Insurance \$ _____

Interest on Mortgage _____

Depreciation (Straight line) _____

Real Estate Taxes _____

Total Allowable Cost of Ownership _____

Lease or Rental Charges Less Cost of Ownership (Adjustment to Schedule D-4) \$ _____

NDAC 75-02-09-13.2. includes property insurance, depreciation, interest on the mortgage, real estate taxes, and plant operation expenses as allowable property costs.

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE H-2/
RELATED PARTY INFORMATION**

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Facility	
Reporting Period	To:
From:	

Complete the following if payments have been made to a related organization. For each type of payment, duplicate or attach additional information as

Payment type	Name of Organization	% of Payment to Organization
Lease		
Accounting		
Other (List)		

Type of Organization	Name of Organization or Individual	Complete Item(s)
Non-Profit Organization		
Church Related		1,5
Association		1,5
Corporation		1,2,5
Other		1,5
Proprietary		
Sole Proprietor		4
Partnership		3,5
Corporation		1,2,5

1. List Board of Directors, Officers, and Addresses.

A.	E.
B.	F.
C.	G.
D.	H.

2. List Stockholders with more than 10% Ownership and Addresses.

A.	E.
B.	F.
C.	G.
D.	H.

3. List Partners and Addresses.

A.	D.
B.	E.
C.	F.

4. Name and Address

--	--

5. State in Which Organized or Incorporated

North Dakota	Other
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PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE I-1/REPORT OF PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY OWNER

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Facility	
Reporting Period	To:
From:	

Type of Organization	Name of Organization or Individual	Complete Item(s)
Non-Profit Organization		
Church Related		1,5
Association		1,5
Corporation		1,2,5
Other		1,5
Proprietary		
Sole Proprietor		4
Partnership		3,5
Corporation		1,2,5

1. List Board of Directors, Officers, and Addresses.	
A.	E.
B.	F.
C.	G.
D.	H.

2. List Stockholders with more than 10% Ownership and Addresses.	
A.	E.
B.	F.
C.	G.
D.	H.

3. List Partners and Addresses.	
A.	D.
B.	E.
C.	F.

4. Name and Address	

5. State in Which Organized or Incorporated	
North Dakota	Other

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE I-2/REPORT OF PSYCHIATRI
RESIDENTIAL TREATMENT FACILITY OPERATOR**

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Facility	
Reporting Period From:	To:

Type of Organization	Name of Organization or Individual	Complete Item(s)
Non-Profit Organization		
Church Related		1,5
Association		1,5
Corporation		1,2,5
Other		1,5
Proprietary		
Sole Proprietor		4
Partnership		3,5
Corporation		1,2,5

1. List Board of Directors, Officers, and Addresses.	
A.	E.
B.	F.
C.	G.
D.	H.

2. List Stockholders with more than 10% Ownership and Addresses.	
A.	E.
B.	F.
C.	G.
D.	H.

3. List Partners and Addresses.	
A.	D.
B.	E.
C.	F.

4. Name and Address	

5. State in Which Organized or Incorporated	
North Dakota	Other

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE J/DEPRECIATION

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Facility	
Reporting Period	To:
From:	

DESCRIPTION	Land Improve-ments	Building	Fixed Equipment	Movable Equipment	Total
Assets: Prior Year's Ending Balance					
Additions					
Deletions					
Ending Balance					
Accumulated Depreciation: Prior Year's Ending Balance					
Less: Accumulated Depreciation of Deletions					
Current Year's Depreciation					
Ending Balance					

1)

1) Total must agree to Schedule C-4, Line 23.

What dollar amount did you use for capitalization of individual assets? \$ _____

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-SCHEDULE K/
INTEREST EXPENSE**

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Facility	
Reporting Period From:	To:

Mortgagor or Lender	Purpose of Loan	Beginning Balance	Ending Balance	Rate	Interest Expense
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
TOTAL					

1) Total must agree to Schedule C-1, Line 24.

1)

**PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT-
SCHEDULE M/SPECIAL RATES**

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Facility	
Reporting Period From:	To:

Please complete the following schedule for facilities of capacity increase of 20% or more, major renovation or construction in excess of \$50,000, or changes in services or staff.

Description of capacity increase or major renovation or construction or changes in services or staff.	
---	--

Description of major renovation or construction or changes in services or staff.	
--	--

Date of capacity increase or major renovation or construction or changes in services or staff.	
--	--

NDAC 75-02-09, Sections 4.c. and 4.d. provide for special rates for facilities having a capacity increase of 20% or more in the year of the capacity increase and for the subsequent rate year; major renovation or construction in excess of \$50,000 in the year a project was completed and placed into service and for the subsequent rate year; or changes in services or staff in the year of increased services or staff and for the subsequent rate year.

Medical Services letter dated March 4, 1997 regarding projected property costs should be reviewed prior to completing this form.

COST CATEGORY	PROJECTED COSTS RATE YEAR	HISTORICAL COSTS REPORT YEAR
Salaries		
Fringe Benefits		
Other Costs		
PROPERTY		
Depreciation		
Interest expense		
Property taxes		
Lease and rental		
Start up costs		
Certain legal fees		
(Less: Adjustments)		
Total Costs		
Census units 1)		
Projected Property Rate		

Requested Rate Adjustment

\$ _____