

## **NURSING FACILITY COST REPORT INSTRUCTIONS**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION PROVIDER AUDIT  
SFN 137 (Rev. 06-16)

### **GENERAL INFORMATION**

The cost report schedules and other data required on the cost report provides the cost basis for the determination of rates to be paid to nursing facilities. The data required conforms to the requirements set forth in the North Dakota Department of Human Services, Rate Setting Manual for Nursing Facilities. Cost data reported must be in conformity with the Rate Setting Manual for Nursing Facilities. 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 form and for general information:

1. Only costs directly affecting resident care will be allowable.
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 (Rev. 06-16) must be used and all schedules must be returned with the cost report. The report is due at the Provider Audit Unit on or before October 1 of the reporting year.
6. In the event a facility fails to file the required completed 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, Rate Setting Manual for Nursing Facilities or contact:

North Dakota Department of Human Services  
Medical Services Division  
600 E. Boulevard Avenue  
Bismarck, ND 58505-0261  
Ph: 701.328.2321      [www.nd.gov/dhs](http://www.nd.gov/dhs)

### **CHECKLIST FOR NURSING FACILITY COST REPORT**

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

North Dakota Department of Human Services  
Fiscal Administration - Provider Audit  
1600 E. Century Avenue Suite 5  
Bismarck, ND 58503  
Ph: 701.328.7560      [www.nd.gov/dhs](http://www.nd.gov/dhs)

### **SCHEDULE A**

Schedule A provides for the completion of general, licensing, occupancy and room type information, and an administrator's and accountant's certification. The number of rooms by type must equal the total licensed number of beds. Complete the number of beds by type of room.

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### **SCHEDULE A-1**

Schedule A-1 provides for the reporting of all fees and charges for private pay residents. The schedule is to be completed using rates and charges effective on or after the beginning of the current rate period. The effective date is the date the facility implemented the charges. Do not use the effective date from the rate notices. Identify all amounts charged for private room accommodations.

### **SCHEDULE B-1**

Schedule B-1 is used to report the number of resident days by type, i.e. in-house or leave, on a monthly basis by licensed section; including licensed nursing facility, licensed basic care, basic care assistance (BCAP), basic care (BC) Alzheimer waiver, and basic care traumatic brain injury (BC TBI); licensed assisted living, licensed hospital, and other.

### **SCHEDULE B-2**

Schedules B-2a and B-2b are used to determine the facility's average case mix weight for the year ended June 30. Multiply Total Days for each classification by the case mix weight. Total the Relative Weight Days column and divide by the Total Days. Schedules B-2a and B-2b case mix days should agree to, or be reconcilable to the facility's June 30 case mix report issued by Medical Services. Include the census reconciliation with the cost report filing.

Schedules B-2c and B-2d are used to report all leave days (days claimed as resident days regardless of remuneration) by classification and by month. All bed hold days, including hospital, therapeutic and institutional leave days, must be reported on Schedule B-2c and B-2d.

### **SCHEDULE B-3**

Schedules B-3a and B-3b are used to report census days by source of payer for forty-eight levels of care, including nursing facility, nursing facility private pay (including Medicaid Expansion), nursing facility Medicare, basic care, including BCAP, BC Alzheimer waiver, BC TBI, and BC private pay; assisted living, hospital, and other. Private pay includes Medicaid Expansion residents, since Medicaid Expansion is private-pay insurance.

### **SCHEDULE B-3a-b**

Schedules B-3a-b, census by payor source, should at least be completed for all licensed nursing home beds.

### **SCHEDULE B-4**

Schedule B-4, Census Questionnaire, should be completed first, so necessary adjustments can be made to the accumulated information on B-1 and B-2(a, b).

### **SCHEDULES C**

Schedules C-1 through C-9 provide for the reporting of cost and revenue information. Schedules C-1, and C-4 through C-9 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-resident related activities. Schedule C-4

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### **SCHEDULES C (con't.)**

identifies costs by cost center and by line item. Direct basic care, hospital, or other direct costs must be entered in the BCAP, BC Alzheimer, BC TBI, assisted living, hospital, and other columns. The amounts on Schedule C-4 are to be used to enter data on Schedule C-1.

### **SCHEDULE C-1**

Schedule C-1 provides for the total costs by cost center summarized on Schedule C-4, adjustments summarized 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 the nursing facility, BCAP, BC Alzheimer, BC TBI, assisted living, hospital, and other are to be calculated using the percentages from Schedules C-2 or C-3.

### **SCHEDULE C-2**

BCAP, BC Alzheimer, BC TBI, assisted living, hospital, and other costs reported on Schedule C-4 may be summarized on Schedule C-1 into the administration, chaplain, property and utilities line. 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 nursing facility and non-nursing facility. If the costs are allocated based on the methodology set forth in Section 11, Cost Allocations of the Rate Setting Manual for Nursing Facilities; this schedule is not necessary.

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 first identified and included as nursing facility, BCAP, BC Alzheimer, BC TBI, assisted living, hospital, or other. The remaining costs are then allocated based on the allocation percentages for the appropriate method reported on Schedule C-3.

### **SCHEDULE C-3**

Schedule C-3 provides statistical data to be used to allocate costs for a combination facility, or a facility with non-resident 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 provides facility cost information. If account totals do not trace directly from the trial balance to Schedule C-4, a separate work paper identifying the account names and amounts that were grouped together, along with the total that ties to C-4, must be submitted.

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### **SCHEDULE C-5**

Schedule C-5 provides 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-6**

Schedule C-6 must be completed. Facilities with fiscal years differing from the report year should submit work papers detailing the reconciliation of costs reported.

### **SCHEDULE C-7**

Schedule C-7 identifies 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 must be completed reconciling total revenue from Schedule C-7 to total financial statement revenue.

### **SCHEDULE C-9**

Schedule C-9 must be completed to answer questions frequently asked of all nursing facilities.

### **SCHEDULES D**

These schedules identify the adjustments required under various sections of the rate setting manual. While we have attempted to identify most of the required adjustments, the preparer should read the manual to determine if additional adjustments should be made. Schedule D recaps all adjustments made on Schedules D-1 through D-4 by cost components of the cost centers. Each adjustment on Schedules D-1 through D-4 is to be listed separately on Schedule D. Total Adjustments are then transferred to Schedule C-1.

### **SCHEDULES D-1 to D-4**

Schedules D-1 through D-4 are used to record adjustments under the Cost Center and cost component directly affected. It may be necessary to allocate the adjustment to Salaries, Fringes and Other when no direct relationship exists. Adjust costs for Medicaid Expansion services paid for by the facility on the Schedules D-1 to D-4.

### **SCHEDULES D-5 to D-6**

Schedules D-5 and D-6 provide information on specific areas which may require adjusting on Schedules D-1 through D-4. A separate Schedule D-5 must be completed for all individuals identifiable as Top Management. Schedule D-6 identifies various facility policies regarding selected costs.

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### **SCHEDULE D-7**

Schedule D-7 is to be completed by a facility which operates or is associated with non-resident related activities. This schedule allows the facility to determine if costs for the non-resident related activity should be included on Schedule C-4 or whether administration costs are to be allocated to the non-resident related activities based on revenues.

If non-resident costs are five percent or greater of total nursing facility costs and have not been included as non-LTC costs on Schedule C-4, the facility will need to include an adjustment of the costs on Schedule D-4 or record the costs on Schedule C-4.

For non-resident related activities which are less than five percent of total facility costs, each activity is to be identified individually on the schedule. Enter gross revenues by activity and calculate the percent of revenues to total. The nursing facility column percentage on Line 11 is determined by subtracting the non-resident related activity percentages from 100%. All percentages should be rounded to 2 decimal places.

Enter total administration costs from Schedule C-1. Subtract administration adjustments previously made on Schedule D. Allocate adjusted administration costs using the percentages on Line 11, after the total adjustment amounts are determined for non-resident related activities, costs must be apportioned to salaries, fringe benefits, malpractice insurance and other costs based on the percentage of the line item to total administration costs.

If the revenue allocation methodology is used and the facility has included the costs for the non-resident related activities as Non-LTC costs on Schedule C-4, an adjustment to exclude the non-resident related costs must be made on Schedule D-4.

### **SCHEDULE D-8**

Schedule D-8 provides for the adjustment of dues, contributions and advertising costs limited by Section 12.9 of the Rate Setting Manual for Nursing Facilities. Provide the detail accounts for dues, contribution, and advertising with this schedule.

### **SCHEDULE E**

Schedule E provides 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 summarizes interest income and identifies various requirements that must be met to qualify for funded depreciation. If the answers to the questions on Schedule F are not in compliance with Section 22 of the Rate Setting Manual for Nursing Facilities, an adjustment must be made and included on Schedule D-4.

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### **SCHEDULE F-1**

Schedule F-1 provides for information on funded depreciation accounts. A separate Schedule F-1 must be completed for each account, CD, etc. included in funded depreciation.

### **SCHEDULE G**

Schedule G must be completed for each individual who can be included in one of the categories listed on the schedule.

### **SCHEDULES H**

These schedules provide for reporting the actual costs of ownership of a facility leased from a related party and information on the related party organization.

### **SCHEDULE I**

These schedules provide for organizational information on the owners and operators of the facility.

### **SCHEDULE J**

Schedule J provides information on the assets and related depreciation expense of the facility.

### **SCHEDULE K**

Schedule K provides information on debt and interest expense claimed by the facility. Identify workers compensation and vendor interest expense.

### **SCHEDULE L**

Schedule L provides information on lease or rental of building and equipment from non-related parties.

### **SCHEDULE M**

Schedule M is the reconciliation of the Resident Trust Accounts to the combined resident bank account to the latest bank statement received by the facility. It does not necessarily have to be completed as of the end of the facility's fiscal year.

### **SCHEDULE O**

Schedule O provides information on projected property costs. This schedule may be completed if a projected property rate is requested by the facility and only if construction, renovations, or replacements in excess of \$100,000 occurred during the report year. Projected property costs are those to be incurred for the rate year.

### **SCHEDULE O-1**

Schedule O-1 provides for the computation of a 12 year property rate adjustment if projected property costs previously included in a rate year exceed the historical costs. If a facility's reported costs include 12 months of costs in the report year, and the projected property rate became effective on or after January 1, 1998, the computation must be made.

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### **SCHEDULE P**

Schedule P provides information on costs and hours for various employees / contracted labor. Also it requires providing salaries and hours included on schedule C-4 that are for the nursing facility.

### **SCHEDULES Q-1 to Q-2**

Schedules Q-1 and Q-2 provide information in order for sending facilities to identify all allowable flood costs due to unforeseeable expenses.

A sending facility has two options when completing their June 30th cost report. The facility must identify on the cost report which option they have chosen to account for expenses due to the flood. The facility must either:

1. Request a rate increase for the remainder of the rate year as an unforeseeable expense under Section 29.2 of the Rate Setting Manual. In order to request the rate increase:
  - a. Submit a written request to the Department requesting a rate increase due to unforeseeable expenses. The request must be received by May 31st.
  - b. Complete Schedules Q-1 and Q-2 in order to identify all allowable flood related expenses. Submit these schedules to the Department by June 15th. This will allow the rate increase to be effective August 1st.
  - c. To complete the June 30th cost report:
    - i. Complete Schedule C-4 showing all costs incurred during the report year. This would include the flood related costs.
      1. An adjustment must be done on Schedule D for expenses reimbursed by FEMA and/or insurance.
    - ii. Complete Schedules Q-1 and Q-2 in order to identify allowable flood related expenses.
      1. An adjustment must be done on Schedule D to offset these expenses.
    - iii. Complete Schedule B-2ef to report the census days during the evacuation. This schedule is for reconciliation and informational purposes. These days will not be used in calculating the facility's January 1st rates.
2. Include flood related costs on the June 30th cost report. These costs will be included in the January 1st rate calculation. In order to complete the cost report:

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### **SCHEDULES Q-1 to Q-2 (con't.)**

- a. Complete Schedule C-4 showing all costs incurred during the report year. This would include the flood related costs.
  - i. An adjustment must be done on Schedule D for expenses reimbursed by FEMA and/or insurance.
- b. Complete Schedules Q-1 and Q-2 in order to identify allowable flood related expenses. These schedules are for reconciliation and informational purposes.
- c. Complete Schedule B-2ef to report the census days during the evacuation. This schedule is for reconciliation and informational purposes. These days will be included in the facility's census days when calculating the facility's January 1st rates.

### **SCHEDULE R**

Schedule R provides information in order for receiving facilities to identify all allowable flood costs due to unforeseeable expenses. A receiving facility has two options when completing their June 30th cost report. The facility must identify on the cost report which option they have chosen to account for expenses related to caring for residents evacuated due to the flood. The facility must either:

1. Include the costs related to caring for the residents who were evacuated to their facility due to the flood. The costs will be included in the facility's costs when calculating the facility's January 1st rates. In order to complete the cost report:
  - a. Complete Schedule C-4 showing all costs incurred during the report year. This would include the costs related to caring for residents who were evacuated to their facility due to the flood.
  - b. Complete Schedule R to include the revenue received from the sending facility.
  - c. Complete Schedule B-2gh to report the census days for the residents who were evacuated to their facility due to the flood. These days will be included in the facility's census days when calculating the facility's January 1st rates.
2. Exclude the costs related to caring for the residents who were evacuated to their facility due to the flood. The costs will not be included in the facility's costs when calculating the facility's January 1st rates. If the facility is unable to separately identify these costs they may offset the revenue instead. In order to complete the cost report:
  - a. Complete Schedule C-4 showing all costs incurred during the report year. This would include the costs related to caring for residents who were evacuated to their facility due to the flood.

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### **SCHEDULE R (con't.)**

- b. Complete Schedule R to include the costs or revenue related to caring for the residents who were evacuated to their facility due to the flood.
  - i. An adjustment must be made on Schedule D to offset the costs or revenue against the appropriate cost categories.
- c. Complete Schedule B-2gh to report the census days for the residents who were evacuated to their facility due to the flood. This schedule will be used for reconciliation and informational purposes. These days will not be used in calculating the facility's January 1st rates.

### **SCHEDULES S to S-1**

Higher education costs for employees and individuals are allowable, however these costs may not exceed an aggregate of \$15,000. All higher education costs are reported on Schedule C-4, line 40 as pass through costs. Allowable and nonallowable education costs are reported on Schedule S and the nonallowable costs are adjusted on Schedule D-2.

Under section 12 of the Rate Setting Manual for Nursing Facilities, the cost of education cannot exceed an aggregate of \$15,000 per employee for the combined amount for repayment of an employee's student loans and for education expense for an individual who is currently enrolled.

The Total column on Schedule S-1 plus the Total from Schedule S must agree to the total amount on Schedule C-4, Line 40, Higher Education Costs.

### **SCHEDULE S**

Schedule S is to be used if the facility provides for the repayment of the employee's student loan. based on The Rate Setting Manual for Nursing Facilities, section 12.37.a.

Provide the employee's name in the first column and answer Yes/No to the second, third, and fourth columns Student Loans Related to Prior Education, Attended an Accredited / Technical Facility and Used for Materials, Books or Tuition per employee who received education costs. The fifth column Position Employee Prepared for & is in that Position is to be used to provide the position that the employee's course of study prepared the employee for a position at the facility and the employee is in that position.

Column six Amount of Employee's Education Expense is to provide the amount of the education expense of the employee not the employer expense. Columns seven and eight Amount Allowable Student Loan and Employee Aggregate are to provide the amount of the employee's allowable student loan and the amount paid in aggregate per employee.

Education Costs Per Employee is for the facility to report amounts the facility paid for repayment of an employee's student loans related to educational expenses incurred by the employee prior to the

## **NURSING FACILITY COST REPORT INSTRUCTIONS**

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### **SCHEDULE S (cont.)**

current cost report year. The Total column on Schedule S plus the Total from Schedule S-1 must agree to the total amount on Schedule C-4, Line 40, Higher Education Costs.

Unallowable Education Costs are for the facility to report any amounts included in Education Costs Per Employee that are nonallowable based on The Rate Setting Manual for Nursing Facilities, section 12.37.a. and must be adjusted on Schedule D-2 or to offset a previous Health Department grant and other reimbursements.

Repayment on Default is for the facility to report any amounts the employee has repaid due to default of agreements or termination of employment and must be offset on Schedule D-2.

### **SCHEDULE S-1**

Schedule S-1 is to be used if the facility claiming education expense for an individual who is currently enrolled in an accredited academic or technical educational facility .

Provide the individual's name in the first column and answer Yes/No to the second, third, and sixth columns Attended an Accredited / Technical Facility; Used for Materials, Books or Tuition, and Minimum Commitment / Repayment Plan per individual who received education payments.

Column four Amount of Individual's Education Expense is to provide the amount of the education expense of the individual not the employer expense. The fifth column for Individual Aggregate is to be used to provide the amount provided for the individuals educational expense in aggregate to date.

Education Costs Per Individual is for the facility to report amounts the facility paid for education expense for an individual who is currently enrolled in an accredited academic or technical educational facility.

Unallowable Education Costs are for the facility to report any amounts included in Education Costs per individual that are nonallowable based on The Rate Setting Manual for Nursing Facilities, section 37.b. and must be adjusted on Schedule D-2.

Repayment on Default is for the facility to report any amounts the individual has repaid due to default of agreements or termination of employment and must be offset on Schedule D-2.

### **SCHEDULE T**

Bad debts for charges incurred on or after January 1, 1990, and fees paid for the collection of those bad debts are allowable provided all requirements of The Rate Setting Manual for Nursing Facilities section 17 are met. Bad debt costs are included on Schedule C-4, Line 41 as a pass-through cost. The Rate Setting Manual for Nursing Facilities Section 10.7. provides, as other pass-through costs, "Allowable bad debts expense under section 17 in the report year in which bad debt is determined to be uncollectible with no likelihood of future recovery."

## NURSING FACILITY COST REPORT INSTRUCTIONS

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### **SCHEDULE T (con't.)**

Schedule T is used to report all nursing facility bad debt costs. In addition, it requires providing the breakdown of bad debt amongst Medicaid, Medicare, and private pay residents. Nonallowable facility bad debt costs must be included with the adjustment for all nonallowable bad debts on Schedule D-4 in accordance with The Rate Setting Manual for Nursing Facilities section 17.

The Rate Setting Manual for Nursing Facilities Section 17.1. provides, "Bad debts for charges incurred on or after January 1, 1990, and fees paid for the collection of those bad debts are allowable provided all requirements of this subsection are met."

- a. The bad debt must result from nonpayment of the payment rate or part of the payment rate.
- b. The facility shall document that reasonable collection efforts have been made, the debt was uncollectible, and there is no likelihood of future recovery. Reasonable collection efforts include pursuing all avenues of collection available to the facility including liens and judgments. In instances where the bad debt is owed by a person determined to have made a disqualifying transfer or assignment of property for the purpose of securing eligibility for medical assistance benefits, the facility shall document that it has made all reasonable efforts to secure payment from the transferee, including the bringing of an action for a transfer in fraud of creditors.
- c. The collection fee may not exceed industry standards for collection agencies and the amount of the bad debt.
- d. The bad debt may not result from the facility's failure to comply with federal and state laws, state rules, and federal regulations.
- e. The bad debt may not result from nonpayment of a private room rate in excess of the established rate, charges for special services not included in the established rate or charges for bed hold days not billable to the medical assistance program under Subsection 3, 4, 5, or 6 of Section 6.
- f. The facility shall have an aggressive policy of avoiding bad debt expense that limits potential bad debts. The facility shall document that the facility has taken action to limit bad debts for individuals who refuse to make payment.

The Rate Setting Manual for Nursing Facilities Section 17.2. provides, "Allowable bad debt expense may not exceed debt associated with 180 days of resident care per year or a total of 360 days of resident care for any one individual."

The Rate Setting Manual for Nursing Facilities Section 17.3. provides, "Finance charges on bad debts allowable under subsections 1 and 2 are allowable only if the finance charges have been offset as interest income."

**NURSING FACILITY COST REPORT - CHECKLIST**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
 SFN 137 (Rev. 06-16)

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

| SCHEDULE     | DESCRIPTION  | COMPLETED         |                     | Not Applicable |
|--------------|--|-------------------|---------------------|----------------|
|              |  | Schedule Provided | Substitute Schedule |                |
| A            | General Information and Certification                |                   |                     |                |
| A-1          | Private Pay Fees and Charges                         |                   |                     |                |
| B-1          | Census Data  |                   |                     |                |
| B-2(a,b)     | Case Mix Census Data                                 |                   |                     |                |
| B-2(c,d)     | Leave Census Data                                    |                   |                     |                |
| B-3(a,b)     | Case Mix Census Data by Payor Sources                |                   |                     |                |
| B-4          | Census Questionnaire                                 |                   |                     |                |
| C-1          | Cost Summary and Allocation                          |                   |                     |                |
| C-2          | Allocation with Direct Costs                         |                   |                     |                |
| C-3          | Statistical Data                                     |                   |                     |                |
| C-4          | Statement of Facility Cost                           |                   |                     |                |
| C-5          | Fringe Benefits                                      |                   |                     |                |
| C-6          | Cost Reconciliation                                  |                   |                     |                |
| C-7          | Revenues   |                   |                     |                |
| C-8          | Revenue Reconciliation                               |                   |                     |                |
| C-9          | Nursing Facility Questionnaire                       |                   |                     |                |
| D            | Adjustments Summary                                  |                   |                     |                |
| D-1 thru D-4 | Adjustments  |                   |                     |                |
| D-5          | Top Management Compensation                          |                   |                     |                |
| D-6          | Adjustment Questionnaire                             |                   |                     |                |
| D-7          | Administration Cost Allocation                       |                   |                     |                |
| D-8          | Dues, Contributions and Advertising Adjustment       |                   |                     |                |
| E            | Summary of Home Office Costs                         |                   |                     |                |
| F            | Interest Income                                      |                   |                     |                |
| F-1          | Funded Depreciation                                  |                   |                     |                |
| G            | Compensation   |                   |                     |                |
| H-1          | Related Party Lease                                  |                   |                     |                |
| H-2          | Related Party Information                            |                   |                     |                |
| I-1          | Report of Nursing Facility Owner                     |                   |                     |                |
| I-2          | Report of Nursing Facility Operator                  |                   |                     |                |
| J            | Depreciation   |                   |                     |                |
| K            | Interest   |                   |                     |                |
| L            | Lease or Rental Information                          |                   |                     |                |
| M            | Resident Trust Account Reconciliation                |                   |                     |                |
| O            | Projected Property Rate                              |                   |                     |                |
| O-1          | Property Adjustment                                  |                   |                     |                |
| P            | Employee and Contracted Labor Information            |                   |                     |                |
| Q-1          | Sending Facility Costs                               |                   |                     |                |
| Q-2          | Sending Facility Evacuation Period Costs and Revenue |                   |                     |                |
| R            | Receiving Facility Costs                             |                   |                     |                |
| S            | Higher Education Costs                               |                   |                     |                |
| S-1          | Higher Education Costs                               |                   |                     |                |
| T            | Bad Debt Costs                                       |                   |                     |                |

RETURN THIS AND ALL OTHER SCHEDULES



**NURSING FACILITY COST REPORT-SCHEDULE A-1/  
PRIVATE PAY FEES AND CHARGES**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

The Rate Setting Manual For Nursing Facilities section 2.2.c. (3) requires "A complete statement of fees and charges for private-pay residents for the report year."

| GROUP | CASE-MIX CLASSIFICATION                        | RATE | EFFECTIVE DATE | RATE | EFFECTIVE DATE |
|-------|--|------|----------------|------|----------------|
| RAE   | Rehabilitation                                 |      |                |      |                |
| RAD   | Rehabilitation                                 |      |                |      |                |
| RAC   | Rehabilitation                                 |      |                |      |                |
| RAB   | Rehabilitation                                 |      |                |      |                |
| RAA   | Rehabilitation                                 |      |                |      |                |
|       |  |      |                |      |                |
| ES3   | Extensive Services Level 3                     |      |                |      |                |
| ES2   | Extensive Services Level 2                     |      |                |      |                |
| ES1   | Extensive Services Level 1                     |      |                |      |                |
|       |  |      |                |      |                |
| HE2   | Special Care High with Depression              |      |                |      |                |
| HE1   | Special Care High with No Depression           |      |                |      |                |
| HD2   | Special Care High with Depression              |      |                |      |                |
| HD1   | Special Care High with No Depression           |      |                |      |                |
| HC2   | Special Care High with Depression              |      |                |      |                |
| HC1   | Special Care High with No Depression           |      |                |      |                |
| HB2   | Special Care High with Depression              |      |                |      |                |
| HB1   | Special Care High with No Depression           |      |                |      |                |
| LE2   | Special Care Low with Depression               |      |                |      |                |
| LE1   | Special Care Low with No Depression            |      |                |      |                |
| LD2   | Special Care Low with Depression               |      |                |      |                |
| LD1   | Special Care Low with No Depression            |      |                |      |                |
| LC2   | Special Care Low with Depression               |      |                |      |                |
| LC1   | Special Care Low with No Depression            |      |                |      |                |
| LB2   | Special Care Low with Depression               |      |                |      |                |
| LB1   | Special Care Low with No Depression            |      |                |      |                |
|       |  |      |                |      |                |
| CE2   | Clinically Complex with Depression             |      |                |      |                |
| CE1   | Clinically Complex with No Depression          |      |                |      |                |
| CD2   | Clinically Complex with Depression             |      |                |      |                |
| CD1   | Clinically Complex with No Depression          |      |                |      |                |
| CC2   | Clinically Complex with Depression             |      |                |      |                |
| CC1   | Clinically Complex with No Depression          |      |                |      |                |
| CB2   | Clinically Complex with Depression             |      |                |      |                |
| CB1   | Clinically Complex with No Depression          |      |                |      |                |
| CA2   | Clinically Complex with Depression             |      |                |      |                |
| CA1   | Clinically Complex with No Depression          |      |                |      |                |
|       |  |      |                |      |                |
| BB2   | Behavior/Cognition with Restorative Nursing    |      |                |      |                |
| BB1   | Behavior/Cognition with No restorative Nursing |      |                |      |                |
| BA2   | Behavior/Cognition with Restorative Nursing    |      |                |      |                |
| BA1   | Behavior/Cognition with No restorative Nursing |      |                |      |                |



**NURSING FACILITY COST REPORT-SCHEDULE B-1/CENSUS DATA**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| MONTH     | LICENSED SECTION |       |          |                       |       |          |           |       |          |          |       |          |
|-----------|------------------|-------|----------|-----------------------|-------|----------|-----------|-------|----------|----------|-------|----------|
|           | NURSING FACILITY |       |          | BASIC CARE            |       |          |           |       |          |          |       |          |
|           | In-house         | Leave | Subtotal | BASIC CARE ASSISTANCE |       |          | ALZHEIMER |       |          | TBI      |       |          |
|           | In-house         | Leave | Subtotal | In-house              | Leave | Subtotal | In-house  | Leave | Subtotal | In-house | Leave | Subtotal |
| July      |                  |       |          |                       |       |          |           |       |          |          |       |          |
| August    |                  |       |          |                       |       |          |           |       |          |          |       |          |
| September |                  |       |          |                       |       |          |           |       |          |          |       |          |
| October   |                  |       |          |                       |       |          |           |       |          |          |       |          |
| November  |                  |       |          |                       |       |          |           |       |          |          |       |          |
| December  |                  |       |          |                       |       |          |           |       |          |          |       |          |
| January   |                  |       |          |                       |       |          |           |       |          |          |       |          |
| February  |                  |       |          |                       |       |          |           |       |          |          |       |          |
| March     |                  |       |          |                       |       |          |           |       |          |          |       |          |
| April     |                  |       |          |                       |       |          |           |       |          |          |       |          |
| May       |                  |       |          |                       |       |          |           |       |          |          |       |          |
| June      |                  |       |          |                       |       |          |           |       |          |          |       |          |
| Total     |                  |       |          |                       |       |          |           |       |          |          |       |          |

1) 1) 1) 1)

| MONTH     | LICENSED SECTION CONTINUED |       |          |          |       |          |          |       |          |       |
|-----------|----------------------------|-------|----------|----------|-------|----------|----------|-------|----------|-------|
|           | ASSISTED LIVING            |       |          | HOSPITAL |       |          | OTHER    |       |          | TOTAL |
|           | In-house                   | Leave | Subtotal | In-house | Leave | Subtotal | In-house | Leave | Subtotal |       |
| July      |                            |       |          |          |       |          |          |       |          |       |
| August    |                            |       |          |          |       |          |          |       |          |       |
| September |                            |       |          |          |       |          |          |       |          |       |
| October   |                            |       |          |          |       |          |          |       |          |       |
| November  |                            |       |          |          |       |          |          |       |          |       |
| December  |                            |       |          |          |       |          |          |       |          |       |
| January   |                            |       |          |          |       |          |          |       |          |       |
| February  |                            |       |          |          |       |          |          |       |          |       |
| March     |                            |       |          |          |       |          |          |       |          |       |
| April     |                            |       |          |          |       |          |          |       |          |       |
| May       |                            |       |          |          |       |          |          |       |          |       |
| June      |                            |       |          |          |       |          |          |       |          |       |
| Total     |                            |       |          |          |       |          |          |       |          |       |

1) 1) 1)

1) Leave days include hospital and therapeutic leave days.



**NURSING FACILITY COST REPORT-SCHEDULE B-2b/CASE MIX CENSUS DATA**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| AVERAGE RELATIVE WEIGHT/DAY |   |     |     |     |     |     |     |     |     |     |     |     |     |               |                 |   |  |
|-----------------------------|---|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---------------|-----------------|---|--|
| GROUP                       | CENSUS BY CLASSIFICATION  | JUL | AUG | SEP | OCT | NOV | DEC | JAN | FEB | MAR | APR | MAY | JUN | TOTAL DAYS 1) | CASE-MIX WEIGHT | RELATIVE WEIGHT DAYS  |  |
| CE2                         | Clinically Complex with Depression  |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.39            |   |  |
| CE1                         | Clinically Complex with No Depression   |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.25            |   |  |
| CD2                         | Clinically Complex with Depression  |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.29            |   |  |
| CD1                         | Clinically Complex with No Depression   |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.15            |   |  |
| CC2                         | Clinically Complex with Depression  |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.08            |   |  |
| CC1                         | Clinically Complex with No Depression   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.96            |   |  |
| CB2                         | Clinically Complex with Depression  |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.95            |   |  |
| CB1                         | Clinically Complex with No Depression   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.85            |   |  |
| CA2                         | Clinically Complex with Depression  |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.73            |   |  |
| CA1                         | Clinically Complex with No Depression   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.65            |   |  |
| BB2                         | Behavior/Cognition with Restorative Nursing                                     |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.81            |   |  |
| BB1                         | Behavior/Cognition with No restorative Nursing                                  |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.75            |   |  |
| BA2                         | Behavior/Cognition with Restorative Nursing                                     |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.58            |   |  |
| BA1                         | Behavior/Cognition with No restorative Nursing                                  |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.53            |   |  |
| PE2                         | Physical Function with Restorative Nursing                                      |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.25            |   |  |
| PE1                         | Physical Function with No Restorative Nursing                                   |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.17            |   |  |
| PD2                         | Physical Function with Restorative Nursing                                      |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.15            |   |  |
| PD1                         | Physical Function with No Restorative Nursing                                   |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.06            |   |  |
| PC2                         | Physical Function with Restorative Nursing                                      |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.91            |   |  |
| PC1                         | Physical Function with No Restorative Nursing                                   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.85            |   |  |
| PB2                         | Physical Function with Restorative Nursing                                      |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.70            |   |  |
| PB1                         | Physical Function with No Restorative Nursing                                   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.65            |   |  |
| PA2                         | Physical Function with Restorative Nursing                                      |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.49            |   |  |
| PA1                         | Physical Function with No Restorative Nursing                                   |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.45            |   |  |
|                             | Respite care, hospice inpatient respite care, or hospice general inpatient care |     |     |     |     |     |     |     |     |     |     |     |     |               | 1.00            |   |  |
| AAA                         | Not Classified  |     |     |     |     |     |     |     |     |     |     |     |     |               | 0.45            |   |  |
|                             | Sub-Total from Sch. B-2a  |     |     |     |     |     |     |     |     |     |     |     |     |               |                 |   |  |
|                             | Total   |     |     |     |     |     |     |     |     |     |     |     |     |               | 1)              |   |  |
|                             |   |     |     |     |     |     |     |     |     |     |     |     |     |               |                 | AVERAGE RELATIVE WEIGHT/DAY (Relative weight day divided by Total Days) |  |

1) If TOTAL DAYS do not agree to the Department's June 30 case mix report, include reconciliation.















**NURSING FACILITY COST REPORT-SCHEDULE B-3b/CASE MIX CENSUS BY PAYER SOURCE**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

|       |   | Number of Days by Payer Source |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
|-------|---|--------------------------------|----------|----------|------------|-------------|------------------|-----------------------|-----|-----------------|--|-----------------|----------|-------|-------|
| GROUP | LEVEL OF CARE   | Nursing Facility               |          |          |            | Basic Care  |                  |                       |     |                 |  | Assisted Living | Hospital | Other | Total |
|       |   | Private Pay                    | Medicare | Medicaid | Assistance | Private Pay | Alzheimer Waiver | Alzheimer Private Pay | TBI | TBI Private Pay |  |                 |          |       |       |
| CE2   | Clinically Complex with Depression  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CE1   | Clinically Complex with No Depression   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CD2   | Clinically Complex with Depression  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CD1   | Clinically Complex with No Depression   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CC2   | Clinically Complex with Depression  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CC1   | Clinically Complex with No Depression   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CB2   | Clinically Complex with Depression  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CB1   | Clinically Complex with No Depression   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CA2   | Clinically Complex with Depression  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| CA1   | Clinically Complex with No Depression   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| BB2   | Behavior/Cognition with Restorative Nursing                                     |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| BB1   | Behavior/Cognition with No restorative Nursing                                  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| BA2   | Behavior/Cognition with Restorative Nursing                                     |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| BA1   | Behavior/Cognition with No restorative Nursing                                  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PE2   | Physical Function with Restorative Nursing                                      |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PE1   | Physical Function with No Restorative Nursing                                   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PD2   | Physical Function with Restorative Nursing                                      |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PD1   | Physical Function with No Restorative Nursing                                   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PC2   | Physical Function with Restorative Nursing                                      |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PC1   | Physical Function with No Restorative Nursing                                   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PB2   | Physical Function with Restorative Nursing                                      |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PB1   | Physical Function with No Restorative Nursing                                   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PA2   | Physical Function with Restorative Nursing                                      |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| PA1   | Physical Function with No Restorative Nursing                                   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
|       | Respite care, hospice inpatient respite care, or hospice general inpatient care |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
| AAA   | Not Classified  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
|       | Sub-Total from Sch. B-3a  |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |
|       | Total   |                                |          |          |            |             |                  |                       |     |                 |  |                 |          |       |       |

1) Total days must equal Schedule B-1 Total Days

**NURSING FACILITY COST REPORT-SCHEDULE B-4/**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|     |   | YES | NO |
|-----|---|-----|----|
| 1.  | Do you charge private pay residents for the day of death?   |     |    |
| 2.  | Do you charge private pay residents for the day of discharge?   |     |    |
| 3.  | Do you charge private pay residents for the day of admission?   |     |    |
| 4.  | Do you offer private pay residents discounted rates for hospital and leave days?<br>If yes, please specify discounted rates:  |     |    |
| 5.  | Do you charge private pay residents for bed hold days prior to admission?   |     |    |
| 6.  | Have all paid residents days been included in census data on Schedule B-1?<br>If no, indicate the number of days not included.  |     |    |
| 7.  | Have all respite care days been included in census data on Schedule B-1?<br>If no, indicate the number of days not included.  |     |    |
| 8.  | Do all residents, except respite care residents and hospice general inpatient care residents, included in census have a resident assessment?<br>If no, indicate number of days for which no resident assessment is available. |     |    |
| 9.  | Have all Medicaid hospital days reported on the UB04 claim form been coded as the proper bed type?  |     |    |
| 10. | Have all Medicare resident days been reported on the UB04 claim form as the proper bed type?<br>If no, schedule the number of resident days and bed type coded to, on a separate sheet.                                       |     |    |
| 11. | Have Medicare residents dates of death been included in the census?   |     |    |
| 12. | Have census records been maintained on a daily basis?   |     |    |
| 13. | Do census records identify the resident, the type of day, and the resident's classification?  |     |    |
| 14. | Is the leave policy the same for both Medicaid and private pay residents (excluding hospital leave days after 15 days)?   |     |    |

**NURSING FACILITY COST REPORT-SCHEDULE C-1/  
COST SUMMARY AND ALLOCATION**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|  | TOTAL COSTS | FACILITY<br>ADJUST-MENTS | ADJUSTED<br>COSTS | ALLOCATION<br>METHOD | NURSING<br>FACILITY | BCAP |
|--|-------------|--------------------------|-------------------|----------------------|---------------------|------|
| <b>DIRECT CARE COSTS</b>                   |             |                          |                   |                      |                     |      |
| Therapies                                  |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Nursing                                    |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Drugs & Supplies                           |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| <b>OTHER DIRECT CARE COSTS</b>             |             |                          |                   |                      |                     |      |
| Food & Dietary Supplements                 |             |                          |                   |                      |                     |      |
| Laundry                                    |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Social Services                            |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Activities                                 |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| <b>INDIRECT CARE COSTS</b>                 |             |                          |                   |                      |                     |      |
| Administration                             |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Malpractice Insurance                      |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Chaplain                                   |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Pharmacy                                   |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Plant                                      |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Utilities                                  |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Housekeeping                               |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Dietary                                    |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| Medical Records                            |             |                          |                   |                      |                     |      |
| Salaries                                   |             |                          |                   |                      |                     |      |
| Fringe Benefits                            |             |                          |                   |                      |                     |      |
| Other Costs                                |             |                          |                   |                      |                     |      |
| <b>PROPERTY COSTS</b>                      |             |                          |                   |                      |                     |      |
| <b>BCAP</b>                                |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other BCAP Costs                       |             |                          |                   |                      |                     |      |
| <b>BC ALZHEIMER</b>                        |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other BC Alzheimer Costs               |             |                          |                   |                      |                     |      |
| <b>BC TBI</b>                              |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other BC TBI Costs                     |             |                          |                   |                      |                     |      |
| <b>ASSISTED LIVING</b>                     |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other Assisted Living Costs            |             |                          |                   |                      |                     |      |
| <b>HOSPITAL</b>                            |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other Hospital Costs                   |             |                          |                   |                      |                     |      |
| <b>OTHER</b>                               |             |                          |                   |                      |                     |      |
| Admin, Chaplain, Utilities, Property Costs |             |                          |                   |                      |                     |      |
| All Other Non-Nursing Facility Costs       |             |                          |                   |                      |                     |      |
| <b>TOTAL COSTS</b>                         |             |                          |                   |                      |                     |      |

**NURSING FACILITY COST REPORT-SCHEDULE C-1/  
 COST SUMMARY AND ALLOCATION**  
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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|  | BC ALZHEIMER | BC TBI | ASSISTED LIVING | HOSPITAL | OTHER |
|--|--------------|--------|-----------------|----------|-------|
| <b>DIRECT CARE COSTS</b>                   |              |        |                 |          |       |
| Therapies                                  |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Nursing                                    |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Drugs & Supplies                           |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| <b>OTHER DIRECT CARE COSTS</b>             |              |        |                 |          |       |
| Food & Dietary Supplements                 |              |        |                 |          |       |
| Laundry                                    |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Social Services                            |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Activities                                 |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| <b>INDIRECT CARE COSTS</b>                 |              |        |                 |          |       |
| Administration                             |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Malpractice Insurance                      |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Chaplain                                   |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Pharmacy                                   |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Plant                                      |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Utilities                                  |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Housekeeping                               |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Dietary                                    |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| Medical Records                            |              |        |                 |          |       |
| Salaries                                   |              |        |                 |          |       |
| Fringe Benefits                            |              |        |                 |          |       |
| Other Costs                                |              |        |                 |          |       |
| <b>PROPERTY COSTS</b>                      |              |        |                 |          |       |
| <b>BCAP</b>                                |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other BCAP Costs                       |              |        |                 |          |       |
| <b>BC ALZHEIMER</b>                        |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other BC Alzheimer Costs               |              |        |                 |          |       |
| <b>BC TBI</b>                              |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other BC TBI Costs                     |              |        |                 |          |       |
| <b>ASSISTED LIVING</b>                     |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other Assisted Living Costs            |              |        |                 |          |       |
| <b>HOSPITAL</b>                            |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other Hospital Costs                   |              |        |                 |          |       |
| <b>OTHER</b>                               |              |        |                 |          |       |
| Admin, Chaplain, Utilities, Property Costs |              |        |                 |          |       |
| All Other Non-Nursing Facility Costs       |              |        |                 |          |       |
| <b>TOTAL COSTS</b>                         |              |        |                 |          |       |



**NURSING 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 | NURSING FACILITY | BCAP | BC ALZHEIMERS | BC TBI | ASSISTED LIVING | HOSPITAL | OTHER |
|---------------|--|-------|------------------|------|---------------|--------|-----------------|----------|-------|
| 1.            | Nursing 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.            | Admissions or Discharges/Deaths                                |       |                  |      |               |        |                 |          |       |
| 8.            | Total Cost Less Property, Administration, Chaplain & Utilities |       |                  |      |               |        |                 |          |       |
| 9.            | Therapy Salaries (Must be direct costed)                       |       |                  |      |               |        |                 |          |       |
| 10.           | Property<br>Attach workpaper detailing allocation              |       |                  |      |               |        |                 |          |       |
| 11.           | * Other  |       |                  |      |               |        |                 |          |       |
| 12.           | * Other  |       |                  |      |               |        |                 |          |       |
| 13.           | * Other  |       |                  |      |               |        |                 |          |       |
| 14.           | * Other  |       |                  |      |               |        |                 |          |       |
| 15.           | * Other  |       |                  |      |               |        |                 |          |       |
| 16.           | * Other  |       |                  |      |               |        |                 |          |       |
| 17.           | * Other  |       |                  |      |               |        |                 |          |       |
| 18.           | * Other  |       |                  |      |               |        |                 |          |       |
| 19.           | * Other  |       |                  |      |               |        |                 |          |       |
| 20.           | Direct LTC   |       |                  |      |               |        |                 |          |       |

\* Identify

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

DUPLICATE AS NECESSARY

**NURSING 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 | NURSING FACILITY | BCAP | BC ALZHEIMERS | BC TBI | ASSISTED LIVING | HOSPITAL | OTHER |
|---------------|---------|-------|------------------|------|---------------|--------|-----------------|----------|-------|
| 21.           | * Other |       |                  |      |               |        |                 |          |       |
| 22.           | * Other |       |                  |      |               |        |                 |          |       |
| 23.           | * Other |       |                  |      |               |        |                 |          |       |
| 24.           | * Other |       |                  |      |               |        |                 |          |       |
| 25.           | * Other |       |                  |      |               |        |                 |          |       |
| 26.           | * Other |       |                  |      |               |        |                 |          |       |
| 27.           | * Other |       |                  |      |               |        |                 |          |       |
| 28.           | * Other |       |                  |      |               |        |                 |          |       |
| 29.           | * Other |       |                  |      |               |        |                 |          |       |
| 30.           | * Other |       |                  |      |               |        |                 |          |       |
| 31.           | * Other |       |                  |      |               |        |                 |          |       |
| 32.           | * Other |       |                  |      |               |        |                 |          |       |
| 33.           | * Other |       |                  |      |               |        |                 |          |       |
| 34.           | * Other |       |                  |      |               |        |                 |          |       |
| 35.           | * Other |       |                  |      |               |        |                 |          |       |
| 36.           | * Other |       |                  |      |               |        |                 |          |       |
| 37.           | * Other |       |                  |      |               |        |                 |          |       |
| 38.           | * Other |       |                  |      |               |        |                 |          |       |
| 39.           | * Other |       |                  |      |               |        |                 |          |       |
| 40.           | * Other |       |                  |      |               |        |                 |          |       |

\* Identify

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

DUPLICATE AS NECESSARY





**NURSING FACILITY COST REPORT-SCHEDULE C-5/**

**FRINGE BENEFITS**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| BENEFIT TYPE 1)                         | General Ledger Account Number | Direct Amount | Allocable Amount | TOTAL |
|---|-------------------------------|---------------|------------------|-------|
| Social Security & Medicare (FICA) Taxes |                               |               |                  |       |
| Affordable Care Act Taxes               |                               |               |                  |       |
| Unemployment Insurance                  |                               |               |                  |       |
| Workforce Safety & Insurance            |                               |               |                  |       |
| Retirement Benefits or Plans            |                               |               |                  |       |
| Health Insurance                        |                               |               |                  |       |
| Life Insurance                          |                               |               |                  |       |
| Dental Insurance                        |                               |               |                  |       |
| Vision Insurance                        |                               |               |                  |       |
| Uniform Allowances                      |                               |               |                  |       |
| Other (Identify)                        |                               |               |                  |       |
| <b>TOTALS</b>                           |                               |               |                  |       |
|   |                               | 4)            | 5)               | 6)    |

| DEPARTMENT       | Salaries | % of Total Salaries | Share of Benefits | Direct | TOTAL |    |
|------------------|----------|---------------------|-------------------|--------|-------|----|
| Therapies        |          |                     |                   |        |       |    |
| Nursing          |          |                     |                   |        |       |    |
| Laundry          |          |                     |                   |        |       |    |
| Social Services  |          |                     |                   |        |       |    |
| Activities       |          |                     |                   |        |       |    |
| Administration   |          |                     |                   |        |       |    |
| Chaplain         |          |                     |                   |        |       |    |
| Plant Operations |          |                     |                   |        |       |    |
| Housekeeping     |          |                     |                   |        |       |    |
| Dietary          |          |                     |                   |        |       |    |
| Medical Records  |          |                     |                   |        |       |    |
| BCAP             |          |                     |                   |        |       |    |
| BC Alzheimers    |          |                     |                   |        |       |    |
| BC TBI           |          |                     |                   |        |       |    |
| Assisted Living  |          |                     |                   |        |       |    |
| Hospital         |          |                     |                   |        |       |    |
| Other            |          |                     |                   |        |       |    |
| <b>TOTALS</b>    |          |                     |                   |        |       |    |
|                  |          | 2)                  | 3)                | 4)     | 5)    | 6) |

1) Only costs as defined in the Ratesetting Manual for Nursing Facilities, Section 1.26. and 33. can be included as fringe benefits.

2) Must equal Line 1, Total Costs of Schedule C-4.

3) Round to two (2) decimal places, i.e. 10.47%.

4) Totals of these columns must equal.

5) Totals of these columns must equal.

6) Must equal Line 2, Total Costs of Schedule C-4.







**NURSING FACILITY COST REPORT-SCHEDULE C-9/  
NURSING FACILITY QUESTIONNAIRE**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|     |   | YES | NO |
|-----|---|-----|----|
| 1.  | Schedule the reconciliation of the facility census to the Department's MDS Census by Classification on a separate sheet (Sch. B-2(a,b) and Sch. B-2(c,d)).<br>Schedule the residents who died or were discharged and their date of death and / or date of discharge on a separate sheet.  |     |    |
| 2.  | Are there any changes to square footage or changes in rooms/office (Sch. C-3)?<br>If yes, provide support for the changes with the rooms labeled and square footage per room on a separate sheet.   |     |    |
| 3.  | Schedule support for all allocations on Schedule C-3 on a separate sheet.   |     |    |
| 4.  | Are there any non-certified aides salaries reported in nursing (Sch. C-4)?<br>If yes, schedule the non-certified aides salaries and fringe benefits on a separate sheet.  |     |    |
| 5.  | Are there any cognitively impaired individuals employed (Sch. C-4)?<br>If yes, who supervises the individuals and where are the salaries reported?  |     |    |
| 6.  | Are the van driver salaries and fringe benefits reported in plant?<br>If no, who drives the van, where are the salaries and fringe benefits reported, and does that person(s) have any other job duties (Sch. C-4)?   |     |    |
| 7.  | Are therapy supplies and noncapitalized therapy equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 7.1.b.<br>If no, make the appropriate adjustments on Schedule D-1  |     |    |
| 8.  | Schedule the detail of the nursing drugs & supplies accounts, identifying the costs, on a separate sheet (Sch. C-4).<br>Are the nursing drugs and supplies, noncapitalized nursing equipment, and other costs reported in accordance with The Ratesetting Manual for Nursing Facilities, section 7.2.b. through 7.2.e. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1   |     |    |
| 9.  | Are there any direct and other direct contract staffing / consultants (Sch C-4)?<br>If yes, is it an all inclusive contract / consultant rate?<br>If the rate is not all inclusive, schedule the detail of the direct and other direct contract staffing and / or consultants, identifying the costs, on a separate sheet (Sch. C-4) and make the appropriate reassignment to administration on Schedule P<br>If yes, Schedule P must be fully completed. |     |    |
| 10. | Is the noncapitalized laundry equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 8.3.b. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1  |     |    |
| 11. | Is the noncapitalized social service equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 8.4. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1   |     |    |
| 12. | Is the activity equipment other than noncapitalized exercise equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 8.5.b. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1   |     |    |
| 13. | Is the noncapitalized administration equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 9.1. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1   |     |    |

**NURSING FACILITY COST REPORT-SCHEDULE C-9/  
NURSING FACILITY QUESTIONNAIRE**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|  | YES | NO |
|--|-----|----|
| 14. Is the noncapitalized chaplain equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 9.2. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1                                |     |    |
| 15. Is the noncapitalized equipment not included elsewhere reported in plant costs in accordance with The Ratesetting Manual for Nursing Facilities, section 9.4.d. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1 |     |    |
| 16. Is the noncapitalized housekeeping equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 9.5.b. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1                          |     |    |
| 17. Is the noncapitalized medical records equipment reported in accordance with The Ratesetting Manual for Nursing Facilities, section 9.7. (Sch. C-4)?<br>If no, make the appropriate adjustments on Schedule D-1                         |     |    |
| 18. Are there any Medicare Part D diabetic supplies such as syringes, needles, swabs, and insulin reported on Schedule C-4?<br>If yes, schedule the Medicare Part D supplies on a separate sheet.  |     |    |
| 19. Are there "other" fringe benefits reported on Schedule C-5?<br>If yes, schedule and identify "other" fringe benefits on a separate sheet.  |     |    |
| 20. Are there cable TV hookups in common areas and resident rooms (Sch. D).<br>If yes, schedule the number of cable TV hookups for the common areas and resident rooms on a separate sheet.  |     |    |
| 21. Are there NDLTCA dues reported on Sch. C-4?<br>If yes, schedule the NDLTCA dues, provide account detail that ties to the trial balance, and the lobby percent for each year on a separate sheet.                                       |     |    |
| 22. Are there any withdrawals from funded depreciation (Sch. F-1)?<br>If yes, schedule the purpose of the withdrawal on a separate sheet. If the withdrawal(s) was for capital assets schedule the items that were purchased on a          |     |    |
| 23. Are Workforce Safety & Insurance premiums paid annually, quarterly, or monthly (Sch. K)?<br>If not paid annually, how much interest expense was paid for the year?<br>In what account was it reported?                                 |     |    |
| 24. Are there any new loans for the current cost reporting year (Sch. K)?<br>If yes, provide copies on the loan agreement and amortization schedule.   |     |    |
| 25. Schedule the actual cost that the employees or individuals paid (not employer paid) for education expense (Sch. S and Sch. S-1 ) on a separate sheet .   |     |    |
| 26. Schedule the breakdown of residents whom the bad debt pertains, to which dates the bad debt relates, and of what the bad debt expense consists, i.e. resident rate, cable TV, therapy, etc. on a separate sheet (Sch. T).              |     |    |
| 27. Nursing facilities must submit a copy of their PS&R Report #: OD44203, with Paid Dates July 1, 2015 Thru June 30, 2016 and Report Run Date of approximately September 30, 2016 must be submitted by October 7, 2016.                   |     |    |

**NURSING FACILITY COST REPORT-SCHEDULE D/SUMMARY  
OF ADJUSTMENTS TO COST ON SCHEDULES D-1 THRU D-4**  
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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

|  | Total | ADJUSTMENTS |   |   |   |   |   |
|--|-------|-------------|---|---|---|---|---|
|  |       | 1           | 2 | 3 | 4 | 5 | 6 |
| <b>DIRECT CARE COSTS</b>                   |       |             |   |   |   |   |   |
| Therapies                                  |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Nursing                                    |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Drugs & Supplies                           |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| <b>OTHER DIRECT CARE COSTS</b>             |       |             |   |   |   |   |   |
| Food & Dietary Supplements                 |       |             |   |   |   |   |   |
| Laundry                                    |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Social Services                            |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Activities                                 |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| <b>INDIRECT CARE COSTS</b>                 |       |             |   |   |   |   |   |
| Administration                             |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Malpractice Insurance                      |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Chaplain                                   |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Pharmacy                                   |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Plant                                      |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Utilities                                  |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Housekeeping                               |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Dietary                                    |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| Medical Records                            |       |             |   |   |   |   |   |
| Salaries                                   |       |             |   |   |   |   |   |
| Fringe Benefits                            |       |             |   |   |   |   |   |
| Other Costs                                |       |             |   |   |   |   |   |
| <b>PROPERTY COSTS</b>                      |       |             |   |   |   |   |   |
| BCAP                                       |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other BCAP Costs                       |       |             |   |   |   |   |   |
| BC ALZHEIMER                               |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other BC Alzheimer Costs               |       |             |   |   |   |   |   |
| BC TBI                                     |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other BC TBI Costs                     |       |             |   |   |   |   |   |
| <b>ASSISTED LIVING</b>                     |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other Assisted Living Costs            |       |             |   |   |   |   |   |
| <b>HOSPITAL</b>                            |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other Hospital Costs                   |       |             |   |   |   |   |   |
| <b>OTHER</b>                               |       |             |   |   |   |   |   |
| Admin, Chaplain, Utilities, Property Costs |       |             |   |   |   |   |   |
| All Other Non-Nursing Facility Costs       |       |             |   |   |   |   |   |
| <b>TOTAL COSTS</b>                         |       |             |   |   |   |   |   |

**NURSING FACILITY COST REPORT-SCHEDULE I  
OF ADJUSTMENTS TO COST ON SCHEDULES D-**  
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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

|  | ADJUSTMENTS CONTINUED |   |   |    |    |    |    |
|--|-----------------------|---|---|----|----|----|----|
|  | 7                     | 8 | 9 | 10 | 11 | 12 | 13 |
| <b>DIRECT CARE COSTS</b>                   |                       |   |   |    |    |    |    |
| Therapies                                  |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Nursing                                    |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Drugs & Supplies                           |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| <b>OTHER DIRECT CARE COSTS</b>             |                       |   |   |    |    |    |    |
| Food & Dietary Supplements                 |                       |   |   |    |    |    |    |
| Laundry                                    |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Social Services                            |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Activities                                 |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| <b>INDIRECT CARE COSTS</b>                 |                       |   |   |    |    |    |    |
| Administration                             |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Malpractice Insurance                      |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Chaplain                                   |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Pharmacy                                   |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Plant                                      |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Utilities                                  |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Housekeeping                               |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Dietary                                    |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| Medical Records                            |                       |   |   |    |    |    |    |
| Salaries                                   |                       |   |   |    |    |    |    |
| Fringe Benefits                            |                       |   |   |    |    |    |    |
| Other Costs                                |                       |   |   |    |    |    |    |
| <b>PROPERTY COSTS</b>                      |                       |   |   |    |    |    |    |
| BCAP                                       |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other BCAP Costs                       |                       |   |   |    |    |    |    |
| BC ALZHEIMER                               |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other BC Alzheimer Costs               |                       |   |   |    |    |    |    |
| BC TBI                                     |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other BC TBI Costs                     |                       |   |   |    |    |    |    |
| <b>ASSISTED LIVING</b>                     |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other Assisted Living Costs            |                       |   |   |    |    |    |    |
| <b>HOSPITAL</b>                            |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other Hospital Costs                   |                       |   |   |    |    |    |    |
| <b>OTHER</b>                               |                       |   |   |    |    |    |    |
| Admin, Chaplain, Utilities, Property Costs |                       |   |   |    |    |    |    |
| All Other Non-Nursing Facility Costs       |                       |   |   |    |    |    |    |
| <b>TOTAL COSTS</b>                         |                       |   |   |    |    |    |    |

**NURSING FACILITY COST REPORT-SCHEDULE D-1/  
ADJUSTMENTS TO COST**

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|                       |
|-----------------------|
| Facility              |
| Reporting Period      |
| From: _____ To: _____ |

| MANUAL REFERENCE SECTION | DESCRIPTION  | AMOUNT | COST CENTER | COST COMPONENT |
|--------------------------|--|--------|-------------|----------------|
| 7.1.b.                   | Therapy supplies and noncapitalized therapy equipment.   |        |             |                |
| 7.2.b. - 7.2.e.          | Routine hair and personal hygiene items, medically necessary, and durable medical equipment.                                   |        |             |                |
| 8.3.b.                   | Noncapitalized laundry equipment.  |        |             |                |
| 8.5.b.                   | Activity equipment other than noncapitalized exercise equipment.   |        |             |                |
| 8.4.                     | Noncapitalized social service equipment.   |        |             |                |
| 9.1.                     | Noncapitalized administration equipment.   |        |             |                |
| 9.1.p.                   | Travel, except as necessary for training programs for personnel required to maintain licensure, certification, or professional |        |             |                |
| 9.2.                     | Noncapitalized chaplain equipment.   |        |             |                |
| 9.4.d.                   | Noncapitalized equipment not included elsewhere.   |        |             |                |
| 9.5.                     | Noncapitalized housekeeping equipment.   |        |             |                |
| 9.7.                     | Noncapitalized medical records equipment.  |        |             |                |
| 11.3.b.                  | Administrative costs allocated to non-resident related activities. (Schedule D-7)  |        |             |                |
| 12.1.                    | Political contributions.   |        |             |                |
| 12.2.                    | Lobbyist cost.   |        |             |                |
| 12.3.                    | Promotional advertising.   |        |             |                |
| 12.4.                    | Fines or penalties.  |        |             |                |
| 12.5.                    | Legal expenses related to challenges against governmental agencies.  |        |             |                |
| 12.6.                    | Costs related to unionization activities.  |        |             |                |
| 12.7.                    | Memberships in sports, health, fraternal or social organizations.  |        |             |                |
| 12.8.                    | The portion of association or professional organization dues which include unallowable costs.                                  |        |             |                |
| 12.9.                    | Community contributions in excess of \$1,500. (Sch. D-8).  |        |             |                |
| 12.10.                   | Unallowable costs incurred by a home office.   |        |             |                |
| 12.11.                   | Stockholder servicing costs.   |        |             |                |
| 12.12.                   | Corporate costs not related to resident care.  |        |             |                |
| 12.13.                   | Personal comfort costs including telephone, television or cable TV in resident rooms.  |        |             |                |
| 12.14.                   | Fundraising costs.   |        |             |                |
| 12.15.                   | Equipment not related to resident care.  |        |             |                |
| 12.16.                   | Costs related to transfer of any capital asset previously reported by any facility.  |        |             |                |
| SUBTOTAL                 |  |        |             |                |

(Continued)

**NURSING FACILITY COST REPORT-SCHEDULE D-2/  
ADJUSTMENTS TO COST (Continued)**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| MANUAL REFERENCE SECTION | DESCRIPTION  | AMOUNT | COST CENTER | COST COMPONENT |
|--------------------------|--|--------|-------------|----------------|
| 12.17.                   | Unallowable charges by subcontractor or lessor.  |        |             |                |
| 12.18.                   | Cost of meals and lodging for facility personnel, in excess of charges.  |        |             |                |
| 12.19.                   | Depreciation of assets not related to resident care.   |        |             |                |
| 12.20.                   | Non-nursing facility operations and administration costs.  |        |             |                |
| 12.21.                   | Medicare utilization review costs.   |        |             |                |
| 12.22.                   | All costs for services paid directly by the department to an outside provider such as prescription drugs, laboratory, and x-ray costs. |        |             |                |
| 12.23.                   | Unallowable portion of vehicle costs not exclusively used by the facility for resident care.   |        |             |                |
| 12.24.                   | Unsupported travel costs.  |        |             |                |
| 12.25.                   | Additional compensation for employees who are members of the board   |        |             |                |
| 12.26.                   | Board fees in excess of allowable amounts.   |        |             |                |
| 12.27.                   | Travel costs for board meetings in non-facility locations.   |        |             |                |
| 12.28.                   | Discriminatory deferred compensation and pension plans.  |        |             |                |
| 12.29.                   | Employment benefits for nonallowable salaries.   |        |             |                |
| 12.30.                   | Top management life insurance premiums.  |        |             |                |
| 12.31.                   | Personal expenses.   |        |             |                |
| 12.32.                   | Costs not adequately documented.   |        |             |                |
| 12.33.                   | Unallowable taxes.   |        |             |                |
| 12.34.                   | Unvested accrued sick or annual leave.   |        |             |                |
| 12.35.                   | Equipment purchased with local or state agency funds.  |        |             |                |
| 12.36.                   | Non-routine hair care.   |        |             |                |
| 12.37.                   | Education costs.   |        |             |                |
| 12.38.                   | Increased lease cost.  |        |             |                |
| 12.39.                   | Direct and indirect therapy cost; Medicare Part B or nonnursing facility residents.  |        |             |                |
| 12.40.                   | Costs for the acquisition of licensed nursing facility capacity.   |        |             |                |
| 12.41.                   | Goodwill.  |        |             |                |
| 12.42.                   | Lease costs in excess of the amount allocable to the leased space as reported on the Medicare cost report.                             |        |             |                |
| 12.43.                   | Salary costs accrued but not paid within seventy-five days of the cost report yearend.   |        |             |                |
| 12.44.                   | Supplemental payments not offset to costs.   |        |             |                |
| 12.45.                   | Alcohol and tobacco products.  |        |             |                |
|                          | SUBTOTAL   |        |             |                |

(Continued)



**NURSING FACILITY COST REPORT-SCHEDULE D-4/  
ADJUSTMENTS TO COST (Continued)**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| MANUAL REFERENCE SECTION | DESCRIPTION  | AMOUNT | COST CENTER | COST COMPONENT |
|--------------------------|--|--------|-------------|----------------|
| 14.                      | Adjustments to home office costs.  |        |             |                |
| 15.1.                    | Charges for services, facilities and supplies in excess of cost, furnished by a related organization.    |        |             |                |
| 15.2.                    | Rental costs which exceed actual ownership costs between related parties. (Schedule H-1)                 |        |             |                |
| 16.1.                    | Compensation for top management personnel in excess of the limitation. (Schedule D-5)                    |        |             |                |
| 16.3.                    | Compensation in excess of limitation for persons listed in Section 16.3.                                 |        |             |                |
| 17.                      | Nonallowable bad debt.   |        |             |                |
| 18.1.c.                  | Gain or loss on disposition of assets.   |        |             |                |
| 18.2.a.                  | Additional depreciation expense claimed as a result of the use of an accelerated method of depreciation. |        |             |                |
| 18.3.a.                  | Acquisitions of assets, with historical cost of at least \$1,000, claimed as an expense.                 |        |             |                |
| 18.3.b.                  | Repair or maintenance costs in excess of \$5,000 claimed as an expense.                                  |        |             |                |
| 18.6.a.                  | Depreciation costs in excess of allowed valuation after July 1, 1985.                                    |        |             |                |
| 19.1.                    | Unallowable interest expense.  |        |             |                |
| 19.1.f.                  | Interest on the valuation amount exceeding ninety percent of the allowable cost basis.                   |        |             |                |
| 19.3.                    | Interest expense incurred as a result of borrowings from a related party.                                |        |             |                |
| 19.4.                    | Interest income or service charges received from residents for late payments.                            |        |             |                |
| 19.5.                    | Interest expense increase or decrease related to refinancing.  |        |             |                |
| 20.3.                    | Special assessments in excess of \$1,000 which are paid in a lump sum and claimed as an expense.         |        |             |                |
| 22.2.                    | Interest income from a fund not qualifying as funded depreciation.                                       |        |             |                |
| 22.3.                    | Interest income from funded depreciation in excess of accumulated depreciation.                          |        |             |                |
| 22.9.                    | Interest expense for borrowing up to the amount of available funded depreciation.                        |        |             |                |
| 26.2.e.(2)               | Adjustments, errors, or omissions found twelve months after establishment of a final rate.               |        |             |                |
| 28.7.                    | Property rate adjustment   |        |             |                |
|                          |  |        |             |                |
|                          |  |        |             |                |
|                          |  |        |             |                |

SUBTOTAL  
TOTAL SCH D-1 TO D-4

**NURSING FACILITY COST REPORT-SCHEDULE D-5/ WORKSHEET FOR TOP MANAGEMENT PERSONNEL COMPENSATION**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| 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)      | _____    |

**NURSING FACILITY COST REPORT-SCHEDULE D-6/  
ADJUSTMENT QUESTIONNAIRE**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|     |  | 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?<br>What is the facility's rate per mile reimbursement? _____<br>NOTE: Travel costs in excess of the amounts established by the Internal Revenue Service must be offset on Schedule D-2.   |     |    |
| 5.  | Have costs for fees paid to members of board of directors been included in the cost report?  |     |    |
| 6.  | How many board of directors meetings are attributable to fees reported?  |     |    |
| 7.  | What is the facility's policy for reimbursement of director fees?  |     |    |
| 8.  | Does the facility offer a deferred compensation plan or a pension plan to any employees?<br>If yes, is the payment structure the same for all employees?   |     |    |
| 9.  | Description of pension plan(s).  |     |    |
| 10. | Are mileage logs maintained showing beginning and ending odometer readings, destination and purpose of trip?<br>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. |     |    |
| 11. | Have utilization records been kept on a daily basis or usage basis for equipment used in non-resident services.  |     |    |

**NURSING FACILITY COST REPORT-SCHEDULE D-7/ADMINISTRATION  
COST ALLOCATION**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

NOTE: Facilities which operate or are associated with non-resident related activities, i.e., apartments, farms and foundations must allocate administration costs.

|   |     |
|---|-----|
| 1. Description of non-resident related activities.  |     |
| 2. Total costs of the non-resident related activities, exclusive of property, administration, chaplain and utilities costs. (attach work paper showing calculations)  |     |
| Total nursing facility costs, exclusive of property, administration, chaplain and utilities costs. (attach work paper showing calculations)   |     |
| 3. costs. (attach work paper showing calculations)  |     |
| 4. Percent non-resident costs to total nursing facility costs. (Line 2 - Line 3)  |     |
| 5. If Line 4 is five percent or greater, have non-resident costs been included on Schedule C-4 as non basic care costs and a portion of administration costs allocated to non-resident activities on Schedule C-1?                | YES |
| 6. If the answer to 5 is NO, non-resident costs must be included on Schedule C-4 as non-LTC and a portion of administration costs must be allocated to non-resident activities on Schedule C-1.                                   | NO  |
| 7. If Line 4 is less than five percent, administration costs must be allocated to non-resident related activities based on the percent of gross revenues not to exceed percent for each activity using the following methodology: |     |

| ADMINISTRATION ALLOCATION BY REVENUE                   |                  |       |                |        |                 |          |       |       |
|--|------------------|-------|----------------|--------|-----------------|----------|-------|-------|
|  | NURSING FACILITY | BCAP  | BC ALZ-HEIMERS | BC TBI | ASSISTED LIVING | HOSPITAL | OTHER | TOTAL |
| 8. Gross revenues                                      |                  |       |                |        |                 |          |       |       |
| 9. Percent of revenues to total                        |                  |       |                |        |                 |          |       |       |
| 10. 2% limitation                                      |                  | 2.00% | 2.00%          | 2.00%  | 2.00%           | 2.00%    | 2.00% |       |
| 11. Lower of actual % or 2%                            |                  |       |                |        |                 |          |       |       |
| 12. Total administration costs from Schedule C-1.      |                  |       |                |        |                 |          |       |       |
| 13. Less administration adjustments from Schedule D's. |                  |       |                |        |                 |          |       |       |
| 14. Allowable administration costs before allocation.  |                  |       |                |        |                 |          |       |       |
| 15. Administration allocation                          |                  |       |                |        |                 |          |       |       |

**INSTRUCTIONS FOR ADMINISTRATION ALLOCATION BY REVENUE METHOD:**

Enter gross revenues of each non-resident related activity and nursing facility, and total gross revenues on Line 8.  
Determine percent of each activity to total revenues on Line 9.  
Enter lower of Line 9 or Line 10 on Line 11.  
Multiply allowable administration costs from Line 14 times Line 11 and enter on Line 15.  
Administration costs allocated to non-resident related activities must be allocated between salaries, fringes and other costs, and then entered on Schedule D-2.  
NOTE: If administration allocation is made using the Revenue Allocation method and costs for the non-resident related activities have been included on Schedule C-4 as non long-term care, the costs included on Schedule C-4 must be adjusted on Schedule D.

**NURSING FACILITY COST REPORT-SCHEDULE D-8/WORKSHEET  
FOR DUES, CONTRIBUTIONS 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<br>NO LIMITATION | UNALLOW-<br>ABLE | SUBJECT TO<br>LIMITATION |
| 1. Dues   |                            |                  |                          |
| Association dues  |                            |                  |                          |
| Civic and business organization dues  |                            |                  |                          |
| Other   |                            |                  |                          |
| 2. Contributions  |                            |                  |                          |
| Political contributions   |                            |                  |                          |
| Community contributions   |                            |                  |                          |
| Other   |                            |                  |                          |
| 3. Memberships  |                            |                  |                          |
| Sports, health, fraternal, social   |                            |                  |                          |
| Other   |                            |                  |                          |
| 4. Sponsorships   |                            |                  |                          |
| Sports teams  |                            |                  |                          |
| Other   |                            |                  |                          |
| 5. Advertising  |                            |                  |                          |
| Recruitment advertising   |                            |                  |                          |
| Promotional advertising   |                            |                  |                          |
| Other   |                            |                  |                          |
| 6. Other costs  |                            |                  |                          |
| 7. <span style="float: right;">TOTAL</span>   |                            |                  |                          |
| 8. Total Costs subject to limitation (Line 7)   |                            |                  |                          |
| 9. Limitation amount  |                            |                  | \$1,500                  |
| 10. Dues, Contributions and Sponsorships Adjustment (Line 8 - Line 9). The adjustment must be included on Schedule D-1. |                            |                  |                          |

PLEASE PROVIDE DUES, CONTRIBUTIONS AND ADVERTISING ACCOUNT DETAIL





**NURSING FACILITY COST REPORT-SCHEDULE F-1/**

**FUNDED DEPRECIATION**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

This form must be completed for each individual account designated as funded depreciation.

General Ledger Account No.

Identification of account (For example, CD #1111, Passbook Account # 12-345)

| Month | Year | Description | Deposits | Interest | Withdrawals For Other Than Capital Assets | Transfers In (Out) | Amount Expended for Capital Assets |
|-------|------|-------------|----------|----------|---|--------------------|------------------------------------|
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
|       |      |             |          |          |   |                    |                                    |
| TOTAL |      |             |          |          |   |                    |                                    |

1)

|                             |  |  |  |  |  |  |  |
|-----------------------------|--|--|--|--|--|--|--|
| Beginning Balance           |  |  |  |  |  |  |  |
| Add: Interest Earned        |  |  |  |  |  |  |  |
| Deposits                    |  |  |  |  |  |  |  |
| Less: Withdrawals For       |  |  |  |  |  |  |  |
| Non-Capital Assets          |  |  |  |  |  |  |  |
| Transfers                   |  |  |  |  |  |  |  |
| Capital Asset Purchases     |  |  |  |  |  |  |  |
| <b>BALANCE, END OF YEAR</b> |  |  |  |  |  |  |  |

1) Provide a description of how the withdrawals, transfers and amount expended for capital assets were used.

**NURSING FACILITY COST REPORT-SCHEDULE G/  
COMPENSATION CATEGORY**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

- |  |   |
|--|---|
| 1. Sole Proprietor                       | 5. Member of a Governing Board or Group   |
| 2. Partner                               | 6. Bondholder or creditor to which the provider is obligated to pay in excess of five thousand dollars. |
| 3. Corporate Stockholder                 | 7. Individual having an ownership in or is an officer of any related organization.                      |
| 4. Organizer of a Non-Profit Corporation | 8. Any person within the third degree of relationship to any person identified in 1 through 7.          |

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

| Name:<br>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 or Other Employee Who 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.

**NURSING FACILITY COST REPORT-SCHEDULE H-1/  
RELATED PARTY LEASE OR RENTAL**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|   |       |
|---|-------|
| Related Party Name: _____   |       |
| Lease or Rental charges claimed as costs _____  |       |
| Allowable Cost of Ownership<br>(Provide supporting documentation and schedules for indicated costs).        |       |
| Property Insurance  | _____ |
| Interest on Mortgage  | _____ |
| Depreciation (Straight line, using no less than the minimum<br>estimated useful lives published by the AHA) | _____ |
| Real Estate Taxes   | _____ |
| Total Allowable Cost of Ownership   | _____ |
| Lease or Rental Charges Less Cost of Ownership (Adjustment to Schedule D-4)                                 |       |

The Rate Setting Manual For Nursing Facilities section 15 includes property insurance, depreciation, interest on the mortgage, and real estate taxes as allowable property costs.

**NURSING FACILITY COST REPORT-SCHEDULE H-2/  
RELATED PARTY INFORMATION**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

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

| 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 \_\_\_\_\_

**NURSING FACILITY COST REPORT-SCHEDULE I-1/  
REPORT OF NURSING FACILITY OWNER**

SFN 137 (Rev. 06-16) Page 37

|                  |     |
|------------------|-----|
| 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

|                          |              |
|--------------------------|--------------|
| <input type="checkbox"/> | North Dakota |
| <input type="checkbox"/> | Other _____  |

**NURSING FACILITY COST REPORT-SCHEDULE I-2/  
REPORT OF NURSING FACILITY OPERATOR**

SFN 137 (Rev. 06-16) Page 38

|                  |     |
|------------------|-----|
| 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

|                          |              |
|--------------------------|--------------|
| <input type="checkbox"/> | North Dakota |
| <input type="checkbox"/> | Other _____  |

**NURSING FACILITY COST REPORT-SCHEDULE J/DEPRECIATION**

SFN 137 (Rev. 06-16) Page 39

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| DESCRIPTION   | TOTAL | Land Improve-ments | Building | Fixed Equip-ment | Movable Equipment |
|---|-------|--------------------|----------|------------------|-------------------|
| 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 34.

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

**NURSING FACILITY COST REPORT-SCHEDULE K/ INTEREST**

SFN 137 (Rev. 06-16) Page 40

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| Mortgagor or Lender | Purpose of Loan | Beginning Balance | Ending Balance | Rate | Interest Expense |
|---------------------|-----------------|-------------------|----------------|------|------------------|
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
|                     |                 |                   |                |      |                  |
| TOTAL               |                 |                   |                |      |                  |

1) Total must agree to Schedule C-4, Line 35.

1)





**NURSING FACILITY COST REPORT-SCHEDULE O/  
PROJECTED PROPERTY RATE**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

Description of renovation or replacement \_\_\_\_\_

Date project was complete and placed into service \_\_\_\_\_

Number of beds increased or decreased (if any) \_\_\_\_\_

Current licensed capacity \_\_\_\_\_

Please complete the following schedule for facilities with renovations or replacements in excess of \$100,000.

The Rate Setting Manual for Nursing Facilities, sections 28.2. and 28.3. provide for projected property rates for facilities in the year a project was completed and placed into service, 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.

|                           | PROJECTED<br>PROPERTY<br>COSTS<br>RATE YEAR | HISTORICAL<br>PROPERTY<br>COSTS<br>REPORT<br>YEAR |
|---------------------------|---|---|
| Depreciation              |   |   |
| Interest Expense          |   |   |
| Property Taxes & Specials |   |   |
| Lease and Rental          |   |   |
| Start Up Costs            |   |   |
| Certain Legal Fees        |   |   |
| Higher Education Costs    |   |   |
| Bad Debt Costs            |   |   |
| (Less: Adjustments)       |   |   |
| Total Property Costs      |   |   |
| Census units 1)           |   |   |
| Projected Property Rate   |   |   |

1) The greater of actual census from the last cost report or ninety percent of licensed capacity actually in use while construction or renovation was occurring plus ninety-five percent of the licensed capacity put back into use after completion of the project must be used for the first rate. The greater of actual census or ninety-five percent of licensed capacity will be used for subsequent rate years.

Requested Rate Adjustment \$ \_\_\_\_\_

**NURSING FACILITY COST REPORT-SCHEDULE O-1/  
PROPERTY RATE ADJUSTMENT**

SFN 137 (Rev. 06-16) Page 44

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period | To: |
| From:            |     |

Date project was complete and placed into service \_\_\_\_\_

The Rate Setting Manual for Nursing Facilities, section 28.7. states that "At such time as twelve months of property costs are reflected in the report year, the difference between a projected property rate established using Subsection 2 or 3 and the property rate that would otherwise be established based on historical costs must be determined. The property rate established in each of the twelve years, beginning with the first rate year following the use of a property rate established using subsection 2 or 3 may not exceed the property rate otherwise allowable, reduced by one-twelfth of that difference."

Facilities with projected property rates, which became effective on or after January 1, 1998 AND have twelve months of costs in the report year, must make an adjustment to the property rate.

|                           | PROJECTED<br>PROPERTY<br>COSTS<br>RATE YEAR | HISTORICAL<br>PROPERTY<br>COSTS<br>REPORT<br>YEAR |
|---------------------------|---|---|
| Depreciation              |   |   |
| Interest Expense          |   |   |
| Property Taxes & Specials |   |   |
| Lease and Rental          |   |   |
| Start Up Costs            |   |   |
| Certain Legal Fees        |   |   |
| Higher Education Costs    |   |   |
| Bad Debt Costs            |   |   |
| (Less: Adjustments)       |   |   |
| Total Property Costs      |   |   |
| Census units 1)           |   |   |
| Projected Property Rate   |   |   |

3) 4)

| Projected<br>Property Rate | Historical<br>Costs Property<br>Rate | Difference | Applicable<br>Census Units | Total<br>Adjustment |
|----------------------------|--------------------------------------|------------|----------------------------|---------------------|
| 3)                         | 4)                                   |            | Divided by                 | 12 years            |
|                            |                                      |            | Annual adjustment 2)       |                     |

1) Projected property census are actual census during the rate year that the projected property was in effect and historical census are greater of actual census from the cost report in effect for the projected property or ninety-percent of licensed bed capacity available for occupancy.

2) The adjustment must be included on Schedule D-4.

**NURSING FACILITY COST REPORT-SCHEDULE P/  
EMPLOYEE AND CONTRACTED LABOR INFORMATION**

SFN 137 (Rev. 06-16) Page 45

|                           |     |
|---------------------------|-----|
| Facility                  |     |
| Reporting Period<br>From: | To: |

| Cost Center/Component        | Amount<br>Included on<br>Sch. C-4 | Total Hours | Amount<br>Included on<br>Sch.C-4 for<br>the Nursing<br>Facility | Total Hours |
|------------------------------|-----------------------------------|-------------|---|-------------|
| Therapies                    |                                   |             |   |             |
| Salaries-Therapists          |                                   |             |   |             |
| Salaries-Aides               |                                   |             |   |             |
| Sub-Total Therapy Salaries   |                                   |             |   |             |
| Contracted Labor-Therapists  |                                   |             |   |             |
| Contracted Labor-Aides       |                                   |             |   |             |
| Sub-Total Therapy Contracted |                                   |             |   |             |
| Nursing                      |                                   |             |   |             |
| Salaries-RN                  |                                   |             |   |             |
| Salaries-LPN                 |                                   |             |   |             |
| Salaries-Aide                |                                   |             |   |             |
| Salaries-Other               |                                   |             |   |             |
| Sub-Total Nursing Salaries   |                                   |             |   |             |
| Contracted Labor-RN          |                                   |             |   |             |
| Contracted Labor-LPN         |                                   |             |   |             |
| Contracted Labor-Aide        |                                   |             |   |             |
| Sub-Total Nursing Contracted |                                   |             |   |             |
| Laundry                      |                                   |             |   |             |
| Social Services              |                                   |             |   |             |
| Activities                   |                                   |             |   |             |
| Administration               |                                   |             |   |             |
| Chaplain                     |                                   |             |   |             |
| Plant                        |                                   |             |   |             |
| Housekeeping                 |                                   |             |   |             |
| Dietary                      |                                   |             |   |             |
| Medical Records              |                                   |             |   |             |
| Total                        |                                   |             |   |             |

**NURSING FACILITY COST REPORT-SCHEDULE Q-1/  
SENDING FACILITY COSTS FROM RECEIVING FACILITIES FOR FLOOD EVACUEES**

SFN 137 (Rev. 06-16) Page 46

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

Period of evacuation: Begin: \_\_\_\_\_ End: \_\_\_\_\_  
(Begin Date is date first resident was evacuated and End date is date last resident was returned back to facility, exclusive of individuals returning from home.)

Report only revenue and days associated with evacuated individuals for the period they were in the receiving facility and were not actually admitted to receiving facility.

|   | TOTAL | Receiving Facility |
|---|-------|--------------------|--------------------|--------------------|--------------------|--------------------|
| Number of in- house days provided by receiving facility |       |                    |                    |                    |                    |                    |
| Payment made to receiving facility                      |       |                    |                    |                    |                    |                    |

**NURSING FACILITY COST REPORT-SCHEDULE Q-2/  
SENDING FACILITY EVACUATION PERIOD COSTS AND REVENUES**

SFN 137 (Rev. 06-16) Page 47

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

Period of evacuation: Begin: \_\_\_\_\_ End: \_\_\_\_\_  
(Begin Date is date first resident was evacuated and End date is date last resident was returned back to facility, exclusive of individuals returning from home.)

**Section A:** Report all amounts and census billed to any funding source for any day of service regardless of who provided the service.

|   |  |
|---|--|
| Amount billed to all funding sources for period of evacuation |  |
| Total days of services billed to all funding sources          |  |

**Section B:** Report only costs and days associated with evacuated individuals

|   |  |
|---|--|
| Number of days of service provided by sending facility during evacuation period - reconcile to Schedules B-2e and B-2f. |  |
|---|--|

| Costs for Flood Evacuation Period |        |
|-----------------------------------|--------|
|                                   | Amount |
| <b>DIRECT CARE COSTS</b>          |        |
| Therapies                         |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Other Costs                       |        |
| Nursing                           |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Drugs & Supplies                  |        |
| Other Costs                       |        |
| <b>OTHER DIRECT CARE</b>          |        |
| Food & Dietary                    |        |
| Laundry                           |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Other Costs                       |        |
| Social Services                   |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Other Costs                       |        |
| Activities                        |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Other Costs                       |        |
| <b>INDIRECT CARE COSTS</b>        |        |
| Administration                    |        |
| Salaries                          |        |
| Fringe Benefits                   |        |
| Malpractice Insurance             |        |
| Other Costs                       |        |

**NURSING FACILITY COST REPORT-SCHEDULE Q-2/  
SENDING FACILITY EVACUATION PERIOD COSTS AND REVENUES**

SFN 137 (Rev. 06-16) Page 47

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

|   |  |
|---|--|
| Chaplain                                  |  |
| Salaries                                  |  |
| Fringe Benefits                           |  |
| Other Costs                               |  |
| Pharmacy                                  |  |
| Other Costs                               |  |
| Plant                                     |  |
| Salaries                                  |  |
| Fringe Benefits                           |  |
| Utilities                                 |  |
| Other Costs                               |  |
| Housekeeping                              |  |
| Salaries                                  |  |
| Fringe Benefits                           |  |
| Other Costs                               |  |
| Dietary                                   |  |
| Salaries                                  |  |
| Fringe Benefits                           |  |
| Other Costs                               |  |
| Medical Records                           |  |
| Salaries                                  |  |
| Fringe Benefits                           |  |
| Other Costs                               |  |
| PROPERTY COSTS                            |  |
| TOTAL SENDING FACILITY COSTS (to Sch D-3) |  |

1)

1) Report the total adjustment on Schedule D-3 and the adjustment by cost category and cost classification on Schedule D.

**NURSING FACILITY COST REPORT-SCHEDULE R/ RECEIVING  
RECEIVING FACILITY COSTS FOR FLOOD EVACUEES**

SFN 137 (Rev. 06-16) Page 48

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

Report only costs and days associated with individuals who were evacuated from a sending facility. Costs must be identified for each sending facility.

|  | TOTAL | Sending Facility |
|--|-------|------------------|------------------|------------------|------------------|------------------|
| Number of in-house days provided by receiving facility |       |                  |                  |                  |                  |                  |
| Payment received from Sending Facility                 |       |                  |                  |                  |                  |                  |
| <b>DIRECT CARE COSTS</b>                               |       |                  |                  |                  |                  |                  |
| Therapies  |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| Nursing  |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Drugs & Supplies                                       |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| <b>OTHER DIRECT CARE COSTS</b>                         |       |                  |                  |                  |                  |                  |
| Food & Dietary   |       |                  |                  |                  |                  |                  |
| Laundry  |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| Social Services  |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| Activities   |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| <b>INDIRECT CARE COSTS</b>                             |       |                  |                  |                  |                  |                  |
| Administration   |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Malpractice Insurance                                  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |
| Chaplain   |       |                  |                  |                  |                  |                  |
| Salaries   |       |                  |                  |                  |                  |                  |
| Fringe Benefits  |       |                  |                  |                  |                  |                  |
| Other Costs  |       |                  |                  |                  |                  |                  |

**NURSING FACILITY COST REPORT-SCHEDULE R/ RECEIVING  
RECEIVING FACILITY COSTS FOR FLOOD EVACUEES**

SFN 137 (Rev. 06-16) Page 48

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

Report only costs and days associated with individuals who were evacuated from a sending facility. Costs must be identified for each sending facility.

|                          | TOTAL | Sending Facility |
|--------------------------|-------|------------------|------------------|------------------|------------------|------------------|
| Pharmacy                 |       |                  |                  |                  |                  |                  |
| Other Costs              |       |                  |                  |                  |                  |                  |
| Plant                    |       |                  |                  |                  |                  |                  |
| Salaries                 |       |                  |                  |                  |                  |                  |
| Fringe Benefits          |       |                  |                  |                  |                  |                  |
| Utilities                |       |                  |                  |                  |                  |                  |
| Other Costs              |       |                  |                  |                  |                  |                  |
| Housekeeping             |       |                  |                  |                  |                  |                  |
| Salaries                 |       |                  |                  |                  |                  |                  |
| Fringe Benefits          |       |                  |                  |                  |                  |                  |
| Other Costs              |       |                  |                  |                  |                  |                  |
| Dietary                  |       |                  |                  |                  |                  |                  |
| Salaries                 |       |                  |                  |                  |                  |                  |
| Fringe Benefits          |       |                  |                  |                  |                  |                  |
| Other Costs              |       |                  |                  |                  |                  |                  |
| Medical Records          |       |                  |                  |                  |                  |                  |
| Salaries                 |       |                  |                  |                  |                  |                  |
| Fringe Benefits          |       |                  |                  |                  |                  |                  |
| Other Costs              |       |                  |                  |                  |                  |                  |
| PROPERTY COSTS           |       |                  |                  |                  |                  |                  |
| TOTAL COSTS (to Sch D-3) |       |                  |                  |                  |                  |                  |

1)

1) Report the total adjustment on Schedule D-3 and the adjustment by cost category and cost classification on Schedule D.

**NURSING FACILITY COST REPORT-SCHEDULE S/  
HIGHER EDUCATION COSTS**

SFN 137 (Rev. 06-16) Page 49

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

The Rate Setting Manual for Nursing Facilities, section 12.37.a. provides, in part, the cost of education is nonallowable unless "The facility is claiming an amount for repayment of an employee's student loans related to educational expenses incurred by the employee prior to the current cost report year . . . "

The Rate Setting Manual for Nursing Facilities, section 12.37.a.(1) provides, the cost of education is nonallowable unless "The education was provided by an accredited academic or technical educational facility;"

The Rate Setting Manual for Nursing Facilities, section 12.37.a.(2) provides, the cost of education is nonallowable unless "The allowable portion of student loan relates to education expenses for materials, books, or tuition and does not include any interest expense;"

The Rate Setting Manual for Nursing Facilities, section 12.37.a.(3) provides, the cost of education is nonallowable unless "The education expenses were incurred as a result of the employee being enrolled in a course of study that prepared the employee for a position at the facility, and the employee is in that position;" and

The Rate Setting Manual for Nursing Facilities, section 12.37.a.(4) provides, the cost of education is nonallowable unless "The facility claims the amount of student loan repayment assistance for work performed by the employee in the position for which the employee received education, provided the amount claimed per employee may not exceed an aggregate of fifteen thousand dollars, and in any event may not exceed the cost of the employee's education."

| Employee | Student Loans Related to Prior Education? | Attended an Accredited / Technical Facility? | Used for Materials, Books, or Tuition? | Position Employee Prepared for & is in that Position? | Amount of Employee's Education Expense | Amount Allowable Student Loan | Employee Aggregate (not to exceed (\$15,000)) |
|----------|---|--|--|---|--|-------------------------------|---|
|          |   |  |  |   |  |                               |   |
|          |   |  |  |   |  |                               |   |
|          |   |  |  |   |  |                               |   |
|          |   |  |  |   |  |                               |   |
|          |   |  |  |   |  |                               |   |

| Education Costs Per Employee |  |  |  |  |  |  |       |
|------------------------------|--|--|--|--|--|--|-------|
|                              |  |  |  |  |  |  | Total |
| Education Costs              |  |  |  |  |  |  |       |

1)

| Unallowable Education Costs. |  |  |  |  |  |  |                 |
|------------------------------|--|--|--|--|--|--|-----------------|
|                              |  |  |  |  |  |  | Facility Adjust |
| Amount Reported              |  |  |  |  |  |  |                 |
| Allowable Amount             |  |  |  |  |  |  |                 |
| Unallowable Costs            |  |  |  |  |  |  |                 |

2)

| Repayment on Default |  |  |  |  |  |  |                 |
|----------------------|--|--|--|--|--|--|-----------------|
|                      |  |  |  |  |  |  | Facility Offset |
| Repayment            |  |  |  |  |  |  |                 |

2)

1) Total column plus Schedule S-1 Total column must agree to Schedule C-4, Line 40.

2) The adjustment must be included on Schedule D-2.

PLEASE PROVIDE DOCUMENTATION OF HIGHER EDUCATION COSTS

DUPLICATE AS NECESSARY

**NURSING FACILITY COST REPORT-SCHEDULE S-1/  
HIGHER EDUCATION COSTS**

SFN 137 (Rev. 06-16) Page 50

|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

The Rate Setting Manual for Nursing Facilities, section 12.37.b. provides, in part, the cost of education is nonallowable unless "The facility is claiming education expense for an individual who is currently enrolled in an accredited academic or technical educational facility . . . "

The Rate Setting Manual for Nursing Facilities, section 12.37.b.(1) provides, the cost of education is nonallowable unless "The education expense is for materials, books, or tuition;"

The Rate Setting Manual for Nursing Facilities, section 12.37.b.(2) provides, the cost of education is nonallowable unless "The facility claims the education expense annually in an amount not to exceed the individual's education expense incurred during the cost report year;"

The Rate Setting Manual for Nursing Facilities, section 12.37.b.(3) provides, "The aggregate amount of education expense claimed for an individual over multiple cost report periods does not exceed fifteen thousand dollars;" and

The Rate Setting Manual for Nursing Facilities, section 12.7.b. (4) provides, "The facility has a contract with the individual which stipulates a minimum commitment to work for the facility of six thousand six hundred fifty-six hours of employment after completion of the education program, as well as a repayment plan if the individual does not fulfill the contract obligations. The number of hours of employment required may be prorated for an individual who receives less than fifteen thousand dollars in assistance."

| Individual | Attending an Accredited / Technical Facility? | Used for Materials, Books, or Tuition? | Amount of Individual's Education Expense | Individual Aggregate (not to exceed (\$15,000) | Minimum Commitment / Repayment Plan? |
|------------|---|--|--|--|--------------------------------------|
|            |   |  |  |  |                                      |
|            |   |  |  |  |                                      |
|            |   |  |  |  |                                      |
|            |   |  |  |  |                                      |
|            |   |  |  |  |                                      |
|            |   |  |  |  |                                      |

| Education Costs Per Individual |  |  |  |  |  |       |
|--------------------------------|--|--|--|--|--|-------|
|                                |  |  |  |  |  | Total |
| Education Costs                |  |  |  |  |  |       |

1)

| Unallowable Education Costs |  |  |  |  |  |                 |
|-----------------------------|--|--|--|--|--|-----------------|
|                             |  |  |  |  |  | Facility Adjust |
| Amount Reported             |  |  |  |  |  |                 |
| Allowable Amount            |  |  |  |  |  |                 |
| Unallowable Costs           |  |  |  |  |  |                 |

2)

| Repayment on Default |  |  |  |  |  |                 |
|----------------------|--|--|--|--|--|-----------------|
|                      |  |  |  |  |  | Facility Offset |
| Repayment            |  |  |  |  |  |                 |

2)

1) Total column plus Schedule S-1 Total column must agree to Schedule C-4, Line 40.

2) The adjustment must be included on Schedule D-2.

PLEASE PROVIDE DOCUMENTATION OF HIGHER EDUCATION COSTS

DUPLICATE AS NECESSARY

**NURSING FACILITY COST REPORT SCHEDULE T /  
BAD DEBT COSTS**

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|                  |     |
|------------------|-----|
| Facility         |     |
| Reporting Period |     |
| From:            | To: |

| MANUAL REFERENCE SECTION           | DESCRIPTION   | Total 1) | Resident 1 |          |             | Resident 2 |          |             |
|------------------------------------|---|----------|------------|----------|-------------|------------|----------|-------------|
|                                    |   |          | Medicaid   | Medicare | Private Pay | Medicaid   | Medicare | Private Pay |
| 10.7.                              | Determined to be uncollectible with no likelihood of future recovery. 2)  |          |            |          |             |            |          |             |
| 17.1.a.                            | Nonpayment of the rate.   |          |            |          |             |            |          |             |
| 17.1.b.                            | Reasonable collection efforts. 3)   |          |            |          |             |            |          |             |
| 17.1.c.                            | Collection fee not to exceed industry standards for collection agencies & the amount of bad debt.   |          |            |          |             |            |          |             |
| 17.1.d.                            | Failure to comply with federal and state laws, state rules, and federal regulations.  |          |            |          |             |            |          |             |
| 17.1.e.                            | Not to result from a rate in excess of the established rate, special services, or charges for bed hold days not billable to the medical assistance program under section 6.3. to 6.6. |          |            |          |             |            |          |             |
| 17.1.f.                            | Aggressive policy of avoiding bad debt expense that limits potential bad debt. 4)   |          |            |          |             |            |          |             |
| 17.2.                              | Not exceed one hundred eighty days of resident care.  |          |            |          |             |            |          |             |
| 17.3.                              | Finance charges only if the finance charges have been offset as interest income.  |          |            |          |             |            |          |             |
| Reported Nursing Facility Bad Debt |   |          |            |          |             |            |          |             |
| Allowable Bad Debt Costs           |   |          |            |          |             |            |          |             |
| Nonallowable Bad Debt Costs        |   |          |            |          |             |            |          |             |

5)

- 1) Total must be from nursing facility bad debt costs.
- 2) Provide a breakdown of the bad debt by month with number of days for each individual.
- 3) Provide support for reasonable collection efforts for each individual.
- 4) The facility shall document that the facility has taken action to limit bad debts for individuals who refuse to make payment.
- 5) The adjustment must be included with all nonallowable bad debts on Schedule D-4.

PROVIDE DOCUMENTATION OF BAD DEBT COSTS