

# **NURSING FACILITY COST REPORT INSTRUCTIONS**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

FISCAL ADMINISTRATION - PROVIDER AUDIT

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## **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. 06-13) 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 thirty-four levels of care, including nursing facility, nursing facility private pay, nursing facility Medicare, basic care, including BCAP, BC Alzheimer waiver, BC TBI, and BC private pay; assisted living, hospital, and other.

## **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 identifies costs by cost center and by line item. Direct basic care, hospital, or other direct costs

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

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.

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.

### **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

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### **SCHEDULE C-5 (con't.)**

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 workpapers 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.

### **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.

### **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

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### **SCHEDULE D-7 (con't.)**

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.

### **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.

### **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.

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### **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.

### **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.

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### **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:
  - 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.

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

- 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.
  - 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.

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

- 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 are allowable, however these costs may not exceed \$3,750 or 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 Ratesetting Manual for Nursing Facilities, the cost of education cannot exceed \$3,750 per year or an aggregate of \$15,000 per employee for the combined amount of the repayment of student loans and the expense related to current enrollment.

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.

Provide the employees' name in the first column and answer Yes/No to the second and third columns Attended an Accredited / Technical Facility and Used for Materials, Books or Tuition per employee who received education costs. The fourth column Employee is in Position Prepared For 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 five Employee's Hours Worked During Year is to provide the number of hours that the employee worked in the position that the employee's course of study prepared the employee for a position at the facility. Column six Hours Worked Times \$2.25 per Hour takes the Employee's Hours Worked During Year times \$2.25 per hour.

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 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.

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### **SCHEDULE S-1**

Unallowable Education Costs columns 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 37.a. and must be adjusted on Schedule D-2 or to offset a previous Health Department grant and other reimbursements.

Repayment on Default columns are 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 is to be used if the facility provides for education expense for an individual who is currently enrolled in an accredited academic or technical educational facility.

Provide the students' 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 student who received education payments.

The fourth and fifth columns Education Expense Amount not to Exceed \$3,750 and Student Aggregate are to be used to provide the amount provided for the students educational expense in the cost report year and in aggregate to date.

Education Costs Per Student 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 columns are for the facility to report any amounts included in Education Costs per student 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 columns are for the facility to report any amounts the student 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 passthrough cost. The Rate Setting Manual for Nursing Facilities Section 10.7. provides, as other passthrough 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."

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 in accordance with The Rate Setting Manual for Nursing Facilities section 17.

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

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 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 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 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  
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Facility	
Reporting Period	To:
From:	

SCHEDULE	DESCRIPTION	COMPLETED		
		Schedule Provided	Substitute Schedule	Not Applicable
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			

PLEASE RETURN THIS AND ALL OTHER SCHEDULES

**NURSING FACILITY COST REPORT- SCHEDULE A**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

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

LICENSE TYPE	LICENSED NUMBER OF BEDS	NUMBER OF BEDS BY TYPE OF ROOM			NUMBER OF ROOMS BY TYPE		
		PRIVATE	SEMI PRIVATE	OTHER	PRIVATE	SEMI PRIVATE	OTHER
NURSING FACILITY							
BASIC CARE							
BCAP							
ALZHEIMER							
TBI							
ASSISTED LIVING							
HOSPITAL							
OTHER							
TOTAL							

a                      b                      c

- a. Number of beds in Private Room.
- b. Number of beds in Semi-private Room.
- c. Number of beds in Other Accomodation Rooms

LTC CENSUS DAYS	
TOTAL LTC DAYS	
90% OCCUPANCY DAYS	
1. Licensed LTC beds	
2. Days Available (Line 1 X 365 or 366)	
3. Total available days (Line 1 X Line 2)	
4. Required occupancy	
5. Required occupancy days (Line 3 X Line 4)	

ADMINISTRATOR'S CERTIFICATION	
I Certify That I Have Examined This Nursing Facility Cost Report In Its Entirety And To The Best Of My Knowledge It Is A True And Correct Statement Prepared From The Accounts And Records Of This Institution Consistent With The Rate Setting Manual For Nursing Facilities And In Accordance With Instructions.	
Date	Signature of Administrator

ACCOUNTANT'S CERTIFICATION	
I Certify That I Am Independent Of This Facility And Have Examined This Nursing Facility Cost Report In Its Entirety And Have Found The Cost Report Information To Be In Compliance With The Rate Setting Manual For Nursing Facilities And The Cost Finding Principles And Processes Applied On a Basis Consistent With That Of The Prior Year.	
Date	Signature of Preparer or Firm

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

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
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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 A-1/  
PRIVATE PAY FEES AND CHARGES**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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
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				
<b>OTHER CHARGES AND FEES</b>					
Description: Identify all amounts charged for private room accommodations.					Charges

If private pay fees and charges differ from room to room please provide a fee schedule for each room. Please attach any additional information related to private pay fees and charges which is not included above.

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
 SFN 137 (Rev. 06-13) Page 4

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	
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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

SFN 137 (Rev. 06-13) Page 6

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	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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

		Number of Days by Payer Source												
GROUP	LEVEL OF CARE	Nursing Facility			Assist- ance	Basic Care					Assisted Living	Hospital	Other	Total
		Private Pay	Medicare	Medicaid		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/  
CENSUS QUESTIONNAIRE**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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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? 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? If no, indicate the number of days not included.		
7.	Have all respite care days been included in census data on Schedule B-1? 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? 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? 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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES

FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

SFN 137 (Rev. 06-13) Page 12

Facility	
Reporting Period	To:
From:	

	TOTAL COSTS	ADJUSTMENTS	ADJUSTED COSTS	ALLOCATION METHOD	NURSING 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>						
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 C-1/  
COST SUMMARY AND ALLOCATION**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	To:
From:	

	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>					
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					
ASSISTED LIVING					
Admin, Chaplain, Utilities, Property Costs					
All Other Assisted Living Costs					
HOSPITAL					
Admin, Chaplain, Utilities, Property Costs					
All Other Hospital Costs					
OTHER					
Admin, Chaplain, Utilities, Property Costs					
All Other Non-Nursing Facility Costs					
<b>TOTAL COSTS</b>					



**NURSING FACILITY COST REPORT-SCHEDULE C-3/STATISTICAL DATA**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	To:
From:	

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 Attach workpaper detailing allocation								
11.	* Other								
12.	* Other								
13.	* Other								
14.	* Other								
15.	* Other								
16.	* Other								
17.	* Other								
18.	* Other								
19.	Direct Non-LTC								

**NURSING FACILITY COST REPORT-SCHEDULE C-3/STATISTICAL DATA**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
 SFN 137 (Rev. 06-13) Page 14

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
20.	Direct LTC								
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								

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





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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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				
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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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)). 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)? 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)? 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)? If yes, who supervises the individuals and where are the salaries reported?		
6.	Are the van driver salaries and fringe benefits reported in plant? 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. 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). 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)? If no, make the appropriate adjustments on Schedule D-1		
9.	Are there any direct and other direct contract staffing / consultants (Sch C-4)? If yes, is it an all inclusive contract / consultant rate? 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 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)? 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)? 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)? 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)? If no, make the appropriate adjustments on Schedule D-1		

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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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)? If no, make the appropriate adjustments on Schedule D-1		
15.	Is the noncapitalized equipment not included elsewhere reported in food and plant costs in accordance with The Ratesetting Manual for Nursing Facilities, section 9.4.d. (Sch. C-4)? 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)? 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)? 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? If yes, schedule the Medicare Part D supplies on a separate sheet.		
19.	Are there "other" fringe benefits reported on Schedule C-5? 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). 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? 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)? 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)? If not paid annually, how much interest expense was paid for the year? <input type="text"/> In what account was it reported? <input type="text"/>		
24.	Are there any new loans for the current cost reporting year (Sch. K)? If yes, provide copies on the loan agreement and amortization schedule.		
25.	Schedule the actual cost that the employees 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, 2012 through June 30, 2013 and Report Run Date of September 30, 2013.		

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

Page \_\_\_\_ of \_\_\_\_

	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-**  
NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
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Facility	
Reporting Period	To:
From:	

Page \_\_\_\_ of \_\_\_\_

	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							
ASSISTED LIVING							
Admin, Chaplain, Utilities, Property Costs							
All Other Assisted Living Costs							
HOSPITAL							
Admin, Chaplain, Utilities, Property Costs							
All Other Hospital Costs							
OTHER							
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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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Facility	
Reporting Period	To:
From:	

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)**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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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-5/  
WORKSHEET FOR TOP MANAGEMENT PERSONNEL  
COMPENSATION**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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)		
5. Percent of Compensation Allocated to Basic Care		
6. Total Allocated to LTC (Line 4 X Line 5)		

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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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? What is the facility's rate per mile reimbursement? 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? 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? 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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
 FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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 F/  
INTEREST INCOME**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

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

OFFSETS		
ACCOUNT	DESCRIPTION	AMOUNT

FUNDED DEPRECIATION INCOME NOT OFFSET PER SCHEDULE F-1		
ACCOUNT	DESCRIPTION	AMOUNT

OTHER INTEREST INCOME NOT OFFSET		
ACCOUNT	DESCRIPTION	AMOUNT

The following provisions of the Rate Setting Manual for Nursing Facilities, Section 22 must be complied with or interest income must be offset to interest expense.

YES	NO				
		1. Is funded depreciation less than accumulated depreciation?			
		a. Total funded depreciation <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr><tr><td> </td></tr></table>			
		b. Less: interest in account <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr></table>			
		c. Adjusted funded depreciation <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr></table>			
		d. Accumulated depreciation on resident related assets <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td></tr><tr><td> </td></tr></table>			
		2. Have the withdrawals been used for other than capital purchases?			
		If yes, is an adjustment necessary? Identify other purposes			
		3. Have borrowed funds been used for capital purchases rather than using funded depreciation?			
		If yes, has the adjustment been made on Sch. D-4?			



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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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: 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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

Related Party Name: \_\_\_\_\_

Lease or Rental charges claimed as costs

Allowable Cost of Ownership

(Provide supporting documentation and schedules for indicated costs).

Property Insurance

\_\_\_\_\_

Interest on Mortgage

\_\_\_\_\_

Depreciation (Straight line, using no less than the minimum  
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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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Facility	
Reporting Period	
From:	To:

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

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

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

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

4. Name and Address \_\_\_\_\_

5. State in Which Organized or Incorporated

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

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

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

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

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

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

4. Name and Address \_\_\_\_\_

5. State in Which Organized or Incorporated

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

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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)

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

1) Total must agree to Schedule C-4, Line 34.

PLEASE PROVIDE A COPY OF YOUR DETAILED DEPRECIATION SCHEDULES SUPPORTING THE ABOVE FIGURES.

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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

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

1)

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





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

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	To:
From:	

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 PROPERTY COSTS RATE YEAR	HISTORICAL PROPERTY COSTS REPORT 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		

Attach amortization schedules, depreciation schedules, workpapers and other data to support projected costs.

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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

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 PROPERTY COSTS RATE YEAR	HISTORICAL PROPERTY COSTS REPORT 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 Property Rate	Historical Costs Property Rate	Difference	Applicable Census Units	Total 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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

Cost Center/Component	Amount Included on C-4	Total Hours	Amount Included on C-4 for the Nursing 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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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	
<b>Nursing</b>	
Salaries	
Fringe Benefits	
Drugs & Supplies	
Other Costs	
<b>OTHER DIRECT CARE</b>	
Food & Dietary	
Laundry	
Salaries	
Fringe Benefits	
Other Costs	
<b>Social Services</b>	
Salaries	
Fringe Benefits	
Other Costs	
<b>Activities</b>	
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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT  
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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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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Facility	
Reporting Period	
From:	To:

The Ratesetting Manual for Nursing Facilities section 12.37.a. provides, 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 provided:"

The Ratesetting 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 Ratesetting 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 Ratesetting 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."

The Ratesetting 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 at a rate that does not exceed two dollars and twenty-five cents per hour of work performed by the employee in the position for which the employee received education, provided the amount claimed per employee may not exceed the lesser of the allowable student loan or three thousand seven hundred fifty dollars per year or an aggregate of fifteen thousand dollars, and in any event may not exceed the cost of the employee's education."

The Ratesetting Manual for Nursing Facilities section 12.37.c. provides, "The cost of education cannot exceed three thousand seven hundred fifty dollars per year or an aggregate of fifteen thousand dollars per employee for subsection a and subsection b combined."

Employee	Attended an Accredited / Technical Facility?	Used for Materials, Books, or Tuition?	Position Employee Prepared For	Employee's Hours Worked During Year	Hours Worked Times \$2.25 per Hour	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**

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES  
FISCAL ADMINISTRATION-PROVIDER AUDIT UNIT

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Facility	
Reporting Period	
From:	To:

The Ratesetting Manual for Nursing Facilities section 12.37.b. provides, 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 provided"

The Ratesetting 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 Ratesetting 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 or three thousand seven hundred fifty dollars."

The Ratesetting Manual for Nursing Facilities section 12.37.b.(3) provides, the cost of education is nonallowable unless "The aggregate amount of education expense claimed for an individual over multiple cost report periods does not exceed fifteen thousand dollars."

The Ratesetting Manual for Nursing Facilities section 12.37.b. (4) provides, the cost of education is nonallowable unless "The facility has a contract with the individual which stipulates a minimum commitment to work for the facility of one thousand six hundred sixty-four hours of employment after completion of the education program for each year education expense assistance was provided, as well as a repayment plan if the individual does not fulfill the contract obligations."

The Ratesetting Manual for Nursing Facilities section 12.37.c. provides, "The cost of education cannot exceed three thousand seven hundred fifty dollars per year or an aggregate of fifteen thousand dollars per employee for subsection a and subsection b combined."

Student	Attended an Accredited / Technical Facility?	Used for Materials, Books, or Tuition?	Education Expense Amount not to Exceed \$3,750	Student Aggregate (not to exceed (\$15,000)	Minimum Commitment / Repayment Plan?

Education Costs Per Student						
						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**

NORTH DAKOTA DEPARTMENT OF  
HUMAN SERVICES  
FISCAL ADMINISTRATION  
PROVIDER AUDIT UNIT  
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Facility	
Reporting Period	
From:	To:

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.

		Total 1)	Resident 1			Resident 2		
			Medicaid	Medicare	Private Pay	Medicaid	Medicare	Private Pay
Section 10.								
10.7.	Determined to be uncollectible with no likelihood of future recovery?							
Section 17.								
1.a.	Nonpayment of the rate?							
1.b.	Reasonable collection efforts?							
1.c.	Collection fee not to exceed bad debt?							
1.d.	Failure to comply with federal and state laws, state rules, and federal regulations?							
2.	Not exceed one hundred eighty days of resident care per year or aggregate of three hundred sixty days of resident care for any one individual;"							
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								

2)

- 1) Total must be for nursing facility bad debt costs.
- 2) The adjustment must be included with all nonallowable bad debts on Schedule D-4.

PLEASE PROVIDE DOCUMENTATION OF BAD DEBT COSTS

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

NORTH DAKOTA DEPARTMENT OF  
HUMAN SERVICES  
FISCAL ADMINISTRATION  
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Facility	
Reporting Period	
From:	To: 01/00/00

		Resident 3			Resident 4		
Section 10.		Medicaid	Medicare	Private Pay	Medicaid	Medicare	Private Pay
10.7.	Determined to be uncollectible with no likelihood of future recovery?						
Section 17.							
1.a.	Nonpayment of the rate?						
1.b.	Reasonable collection efforts?						
1.c.	Collection fee not to exceed bad debt?						
1.d.	Failure to comply with federal and state laws, state rules, and federal regulations?						
2.	Not exceed one hundred eighty days of resident care per year or aggregate of three hundred sixty days of resident care for any one individual;"						
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							

- 1) Total must be for nursing facility bad debt costs.
- 2) The adjustment must be included with all nonallow

PLEASE PROVIDE DOCUMENTATION OF BAD DEBT COSTS

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

NORTH DAKOTA DEPARTMENT OF  
HUMAN SERVICES  
FISCAL ADMINISTRATION  
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Facility	
Reporting Period	
From:	To:

		Resident 5			Resident 6		
Section 10.		Medicaid	Medicare	Private Pay	Medicaid	Medicare	Private Pay
10.7.	Determined to be uncollectible with no likelihood of future recovery?						
Section 17.							
1.a.	Nonpayment of the rate?						
1.b.	Reasonable collection efforts?						
1.c.	Collection fee not to exceed bad debt?						
1.d.	Failure to comply with federal and state laws, state rules, and federal regulations?						
2.	Not exceed one hundred eighty days of resident care per year or aggregate of three hundred sixty days of resident care for any one individual;"						
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							

- 1) Total must be for nursing facility bad debt costs.
- 2) The adjustment must be included with all nonallow

PLEASE PROVIDE DOCUMENTATION OF BAD DEBT COSTS