



Home Office
FINANCIAL REPORT FOR NON-STATE OWNED INTERMEDIATE CARE FACILITIES
FOR THE MENTALLY RETARDED AND COMMUNITY RESIDENTIAL FACILITIES
FOR THE DEVELOPMENTALLY DISABLED

Name of Home Office:			
Report Type: (Check One)		Period of Report:	
<input type="checkbox"/> [11101] Annual	<input type="checkbox"/> [11103] Historical Report	From:	To:
Home Office Address			
[12110] Street or P.O. Box	[12111] City	[12112] State	[12113] Zip

SCHEDULE P			
Line No.	Schedule of Home Office Expenses		
1	Total unadjusted Home Office Expenses per Attached Statement of Expenses		
Adjustments:			
2	Services the Office of Medicaid Policy and Planning pays for separately or by other programs		
3	Travel not related to resident/patient care		
4	All advertising other than help wanted		
5	Legal, Accounting, and Consulting Fees not related to resident/patient care		
6	Federal Income Taxes		
7	Expenses allocated to facilities outside of Indiana		
8	Expenses allocated to Indiana facilities not certified for Medicaid		
9	Other (Specify)		
10	Other (Specify)		
11	Other (Specify)		
12	Total Adjustments		
13	Total Allowable Home Office Expenses to be Allocated		
14	Method of Allocation: Explain the method used to allocate home office expenses to the individual facilities.		

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Round to the nearest whole number or dollar

Name of Home Office:

SCHEDULE R

Schedule of Allowable Home Office Expenses	Line Number	Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)	
		Provider Number		Provider Number		Provider Number		Hours Worked [07]	Costs [08]
		Hours Worked [01]	Costs [02]	Hours Worked [03]	Costs [04]	Hours Worked [05]	Costs [06]		
Director of Nursing	311								
Registered Nurses	312								
Licensed Practical Nurses	313								
Nurses Aides and Orderlies	314								
Medical Director	315								
Residential Supervisor	316								
House Manager/Parent	317								
Medical and Non-Medical Supplies	318								
QMRP	319								
Other (Specify)	320								
TOTAL DIRECT CARE	328								
Dietary Personnel	331								
Dietician	332								
Raw Food	333								
Other Dietary Expense	337								
TOTAL DIETARY	338								
Laundry Personnel	341								
Housekeeping Personnel	342								
Laundry Supplies & Services	343								
Housekeeping Supplies & Services	344								
TOTAL LAUNDRY & HOUSEKEEPING	348								
Plant Operation Personnel	351								
Utilities - Gas, Water, Electric	352								
Other Plant Operations	357								
TOTAL PLANT OPERATIONS	358								
Interest on Facilities & Equipment	361								
Depreciation - Building & Fixtures	362								
Depreciation - Moveable Equipment	363								
Building Lease/Rent	364								
Equipment Lease/Rent	365								
Insurance (Fire, Property, etc.)	371								
Repairs and Maintenance	372								
Real Estate Taxes	373								
Personal Property Taxes	374								
Other Ownership Costs	377								
TOTAL OWNERSHIP	378								

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Schedule of Allowable Home Office Expenses		Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)				
		Provider Number		Provider Number		Provider Number						
		Line Number	Hours Worked [01]	Costs [02]	Hours Worked [03]	Costs [04]	Hours Worked [05]			Costs [06]	Hours Worked [07]	Costs [08]
		Administrator/Executive Director Salary	381									
Co-Administrator/Program Director Salary	382											
Owner, Related Party, Management	383											
Directors' Fees	384											
Other Home Office Personnel	385											
Office & Clerical Personnel	389											
Legal & Accounting Fees - See Instructions	391											
Advertising - All Other	392											
Advertising - Help Wanted	393											
Travel Expenses - See Instructions	394											
Telephone	395											
License, Dues & Subscriptions	396											
Office Supplies & Postage	397											
Contributions & Donations	398											
Interest - Working Capital	401											
State Gross Receipts & Income Taxes	402											
Utilization Review Costs	403											
Liability Insurance	404											
Owners' Expense - See Instructions	405											
Consultant Fees	406											
Other General & Administrative (Specify)	407											
TOTAL GENERAL & ADMINISTRATIVE	408											
Payroll Taxes	411											
Health Insurance	412											
Life Insurance - Not in Excess of Limits	413											
Workers' Compensation	414											
Qualifying Pensions	415											
Owners' Benefits - See Instructions	416											
Other Qualifying Benefits (Specify)	417											
TOTAL EMPLOYEE BENEFITS	418											

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Name of Home Office:

SCHEDULE R									
Schedule of Allowable Home Office Expenses	Line Number	Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)	
		Provider Number		Provider Number		Provider Number			
		Hours Worked [01]	Costs [02]	Hours Worked [03]	Costs [04]	Hours Worked [05]	Costs [06]	Hours Worked [07]	Costs [08]
Activity Director	421								
Activity Services	422								
Recreational Services	423								
Social Worker	424								
Activity Supplies	425								
Other Social Service Expenses	426								
Recreational Supplies	427								
TOTAL SOCIAL SERVICES	438								
SUBTOTAL	439								
Physical Therapy	441								
Speech and Audiology Therapy	442								
Occupational Therapy	443								
Respiratory Therapy	444								
TOTAL THERAPY SERVICES	448								
Physician/Dentist	453								
Psychiatrist/Psychologist/Behavior Specialist	454								
Pharmacy/Drugs	455								
Vending Machines	456								
Assessment Program Costs	457								
Day Habilitation Services	461								
Day Habilitation Transportation Services	462								
Other (Specify)	463								
TOTAL ANCILLARY	468								
GRAND TOTAL	498								

[49810] Did any of the following costs that are reported on Schedule R incur as a result of an administrative or judicial action or proceeding against any agency of the state or federal government: (a) costs associated with legal fees, (b) costs associated with expert witnesses, (c) accounting fees and consulting fees? If yes, attach a schedule detailing the costs reported, and include the description and line where the cost was reported.

(2) No

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SCHEDULE S							
Analysis of Property	Line Number	Agency Use Only [01]	Historical Cost at Beginning of Period [02]	Additions* [03]	Disposals* [04]	Historical Cost at End of Period [05]	Depreciation Expense This Period [06]
Land	651						
Land Improvements	652						
Building & Building Components	653						
Building Improvements	654						
Moveable Equipment	655						
Vehicles & Other Property-Owners' Expense	656						
Vehicles - Other	657						
Other - Specify	658						
Other - Specify	659						
TOTAL	660						

* Please submit detailed information for any addition or disposal in excess of \$5,000 including: date placed in service or disposed, description and purpose of property, location, and cost basis. Line 660 Column 6 should equal the sum of Lines 362 and 363 of Schedule R.

[66500] Does any item included in this schedule pertain to any property that is not resident/patient related to beds listed in Schedule A? If yes, attach explanation. (1) Yes (2) No

[67102] Was any item included in this schedule acquired directly or indirectly from a related party? If yes, attach explanation. (1) Yes (2) No

[67103] Are the total number of vehicles reported on Line 656 and 657 greater than "one resident/patient care related automobile" and "one vehicle that can be utilized for facility maintenance or resident support or for both users" in accordance with 405 IAC 1-12-8(b)? (1) Yes (2) No

If yes, then identify the date placed in service, make, model, description of use, cost basis, gross weight, property financing reported on Schedule T and the allocation between Line 656 and 657, if applicable.

[67104] Was any asset that was reported as a disposal on this schedule financed by any property financing utilized in the calculation of the capital return factor of the prior rate case? If yes, indicate which financing arrangement. (1) Yes (2) No

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SCHEDULE T

Analysis of Home Office Property Financing	Line Number	Property Financing #1	Property Financing #2	Property Financing #3	Property Financing #4	Property Financing #5
ID Number - For Ratesetter Use Only	701					
Name of Lender	711					
Are Lender and Borrower Related Parties? (Check One)	712	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Description of Property Financed	713					
Original Commitment Date of Loan	716	/ /	/ /	/ /	/ /	/ /
Beginning Date of Payments	717	/ /	/ /	/ /	/ /	/ /
Term of Loan-Amort. Period in Months	718					
Original Amount of Loan	719					
Date of Refinancing This Period (if any)	721	/ /	/ /	/ /	/ /	/ /
Unpaid Balance at Beginning of Period	724					
Unpaid Balance at End of Period	725					
Average Unpaid Balance This Period	726					
Is Interest Rate Fixed or Variable? (Check One)	731	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable	<input type="checkbox"/> (1) Fixed <input type="checkbox"/> (2) Variable
If Fixed, Give Interest Rate	732					
If Variable, Average Interest Rate During Period	735					
If Variable, Interest Rate at End of Period	737					
Amount of Debt Service This Period	741					
Interest Expense This Period	742					
Line Number on Which Expense is Reported	743					
Does Financing Pertain to Only Resident/Patient Related Property? (Check One) If No, Attach Allocation Plan	748	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No
Does Financing Pertain to Any Property That is Defined by Criteria as Owners Expense? (Check One) If Yes, Attach Allocation Plan	749	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No	<input type="checkbox"/> (1) Yes <input type="checkbox"/> (2) No

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SCHEDULE U

Analysis of Home Office Leased Property	Line Number	Lease No. 1	Lease No. 2	Lease No. 3	Lease No. 4
ID Number - For Ratesetter Use Only	751				
Name of Lessor	761				
Are Lessor and Lessee Related Parties?*	762				
Description of Leased Property	763				
Does Lease Pertain to Only Patient/Resident Related Property? (Check One) If No, Attach Allocation Plan	765				
Is the Historical Cost Basis of this Property Included in Schedule S? (Check One)	766				
Does Lease Pertain to Property That is Defined by Criteria as Owners Expense? (Check One)	767				
Date of Commitment on Current Lease	772	/ /	/ /	/ /	/ /
Date of Commitment on Original Lease	773	/ /	/ /	/ /	/ /
Inception Date of Original Lease Agreement**	774	/ /	/ /	/ /	/ /
Minimum Annual Lease Payments Without Executory Costs at Inception Date of Original Lease**	776				
Amount of Lease Payments this Period Without Executory Costs	777				
Line Number on Which Expense is Reported	779				
Incremental Borrowing Rate at Date of Inception**	781				
Lessor's Implicit or Imputed Interest Rate at Date of Inception**	782				
Term of Lease in Months**	783				
Economic Life of Leased Assets in Months**	784				
Fair Market Value of Leased Assets at Date of Inception**	785				
Amount of Guaranteed Residual Value**	786				
Amount of Bargain Purchase Option**	787				
Amount of Bargain Renewal Option*	788				
Is Ownership Transferred to Lessee at End of Lease Term? (Check One)*	789				
Is Lease Payment Contingent Upon Inflation Index or Interest Rate? (Check One) If Yes, Attach Explanation of Contingencies or Methods of Calculation	792	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes
Has an Independent Accountant Ever Made a Determination as to Type of Lease According to GAAP? (Check One)**	795	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes	<input checked="" type="checkbox"/> (1) Yes
Indicate Type of Lease in Accordance with GAAP (Check One)**	796				

* If the answer to Line 762 is "Yes", then report on Schedule S the historical basis of patient/resident related property, report on Schedule T the related financing, and complete Schedule U only from Line 751 through Line 774.

** These items are technical questions relating to FASB 13 and subsequent pronouncements of the AICPA.

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SCHEDULE V

Home Office Balance Sheet Home Office Only Consolidated Combined (attach explanation)
[80100] Check One

Assets	Line Number	Beginning of Period		End of Period	
		[01]	[02]	[03]	[04]
Cash	811				
Accounts receivable	812				
Less: Allowance for Bad Debt	813	<	>	<	>
Prepaid Expenses	814				
Inventories and Supplies	815				
Intercompany Receivables	816				
All Loans to Owners, Officers & Related Parties*	817				
All Assets Not Related to Patient/Resident Care*	818				
Assets Held for Investment*	819				
Property, Plant and Equipment	820				
Less: Accumulated Depreciation	821	<	>	<	>
Other Assets (Specify)	822				
Other Assets (Specify)	823				
TOTAL ASSETS	829				
Liabilities and Equity					
Accounts Payable	840				
Other Current Liabilities	841				
Intercompany Liabilities	842				
Non-Related Party Working Capital Loans	843				
Related Party Working Capital Loans	844				
Property Financing - Patient/Resident Related	845				
Property Financing - Not Related to Patient/Resident Care*	846				
All Loans from Owners, Officers & Related Parties*	847				
Other Long Term Liabilities (Specify)	848				
TOTAL LIABILITIES	849				
Owners' Equity or Fund Balance					
Owners' Capital - Individual Proprietor	851				
Partners' Capital Account - Partnership	852				
Fund Balance - Not for Profit Entity	853				
Capital Stock - Preferred Stock	854				
Common Stock	855				
Additional Paid-In Capital	856				
Retained Earnings	857				
Less: Cost of Treasury Stock	858	<	>	<	>
TOTAL OWNERS' EQUITY OR FUND BALANCE	859				
TOTAL LIABILITIES AND OWNERS' EQUITY	860				

* Attach Explanation

[80200] Check the highest level of service provided by an independent accountant regarding the financial statements covering the report period: Audit Review Compilation None of the Above

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Name of Home Office:

SCHEDULE W			
Reconciliation of Owners' Equity or Fund Balance			
Beginning of Period Balance (Schedule V, Line 859, Column 2)	901		
Increases:			
Revenues Per Financial Statements or Tax Return	905		
Investment by Owners	906		
Transfers from Home Office	907		
Common Stock Sold	908		
Other (Specify)	909		
Other (Specify)	910		
Total Increases	915		
Decreases:			
Expenses Per Financial Statements or Tax Return	920		
Withdrawal by Owners	921		
Transfers to Home Office	922		
Dividends Paid to Stockholders	923		
Other (Specify)	924		
Other (Specify)	925		
Other (Specify)	926		
Total Decreases	930		< >
End of Period Balance (Schedule V, Line 859, Column 4)	940		

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CERTIFICATION STATEMENT

This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to resident/patient care. Expenses not related to resident/patient care have been appropriately identified or removed. I understand that this information is submitted for the purpose of developing payment rates under the Indiana Medicaid Program, and the ultimate payment and satisfaction of claims will be based upon the information contained herein. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law. Declaration of preparer is based on all information of which the preparer has any knowledge. Preparer may (but not required) also include a compilation statement. The Certification Statement submitted to the Rate Setting Contractor must contain original signatures.

Name of Authorized Person	Title / Position	Name of Home Office
Signature of Authorized Person	Date	Telephone Number
		()
Name of Preparer	Title / Position	Address of Preparer
Signature of Preparer	Date	Telephone Number
		()