

**STATE OF INDIANA
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF MEDICAID POLICY AND PLANNING**

Instructions for the Medicaid Financial Report for Non-State Owned
Intermediate Care Facilities for the Mentally Retarded (ICFs/MR) and
Community Residential Facilities for the Developmentally Disabled (CRFs/DD)

GENERAL INSTRUCTIONS

These instructions are for use under the provisions of the Rate Setting Criteria for Non-State Owned ICFs/MR and CRFs/DD (405 IAC 1-12) that are certified as Medicaid providers by the State of Indiana, Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP).

Forms and Information Forms are available from the rate setting contractor at the address below, but providers are requested to reproduce copies locally whenever possible. Information may be obtained by calling 317-846-9521 or 1-800-877-6927. Computerized alternatives to the Financial Report for Non-State Owned ICFs/MR and CRFs/DD prescribed by the Office must receive prior approval before they will be accepted. Contact the rate setting contractor for the approval process. Completed financial reports should be filed with the rate setting contractor on or before the due date.

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Refer to Criteria - Instructions Are Not Comprehensive These instructions are not intended to be comprehensive. In completing the forms, providers should rely on the Criteria as well as other relevant rules and regulations, including generally accepted accounting principles (GAAP).

Suggested Filing Format The forms are used for various filings with the rate setting contractor under provisions of the Criteria. It is recommended that a cover letter, outlining the nature of the filing or request, accompany all forms. The letter should indicate the documents submitted and convey other information or schedules to support the filing. All financial data, except per diem information, should be rounded to the nearest whole number. The information below outlines the types of rate reviews that are applicable under the Criteria.

- A. *Regular annual rate review.* Providers should submit a complete Financial Report for Non-State Owned ICFs/MR and CRFs/DD that coincides with the same time period as the provider's fiscal year end for tax purposes, except where OMPP has granted the provider's request for a one-time election to

use a different Medicaid reporting year in accordance with the Criteria. Providers will receive a regular annual rate review based on the annual report. The annual report is due ninety (90) days after the provider's report year end. Extensions of time may be granted for good cause by the rate setting contractor if requested in writing by the provider before the annual report due date.

- B. *Second rate review.* As allowed for at 405 IAC 1-12-6(b) and (c), providers are permitted one additional rate review during the year. Additional rate reviews shall be completed in the same manner as the annual rate review, using all other limitations in effect at the time the annual review took place. Criteria and reporting instructions are contained in the above referenced rule.
- C. *Capital expenditure rate review -- (greater than 5% change of property basis).* As allowed for at 405 IAC 1-12-6(e), the provider may request a rate review to establish a new basis for computation of the capital return factor portion of the rate. If a provider qualifies for this rate review, they should submit only those schedules of the financial report applicable to the capital return factor including: Schedules I, J, K, L and all information contained on page one of the financial report form. The suggested due date for the capital expenditure rate review is within thirty (30) days after project completion, or thirty (30) days after notification of certification (if applicable), whichever is later.
- D. *Initial interim rate review.* Requests for initial interim rates are due on or before thirty (30) days after notification of the certification date or establishment of a new service. Under 405 IAC 1-12-5(a), initial interim rates for a new operation, a new type of certified service, or a change of provider status, will be set at the greater of the prior provider's then current rate, if applicable, or the fiftieth (50th) percentile rate. This methodology does not require the submission of the Financial Report for Non-State Owned ICFs/MR and CRFs/DD when requesting an initial interim rate.

The request for an initial interim rate shall be accomplished with a cover letter containing the following information:

1. The proposed effective date for the initial interim rate.
 2. A clear explanation of the basis for requesting an initial interim rate under the provisions of 405 IAC 1-12-5(a). Providers should specify whether the basis is a new operation, a new type of certified service, or a change of provider status. Providers that are providing a new type of certified service should specify the new service. Providers that have undergone a change of provider status must complete the Checklist of Management's Representations Concerning Change in Provider Status.
 3. The lowest usual and ordinary charge to private pay residents in effect on the proposed rate effective date for like levels of services, facilities and supplies that are covered by the Medicaid per diem rate under the Criteria.
 4. The provider's fiscal year end for tax purposes.
- E. *Base rate review.* A provider that receives an initial interim rate review must submit a nine (9) month historical financial report for the base rate review. This financial report is due within sixty (60) days

after the end of the initial nine (9) month period. Extensions of time may be granted for good cause by the rate setting contractor if requested in writing by the provider before the historical report due date.

Results of Prior Period Audit Findings The findings and recommendations contained in prior period field audits, or inquiry by FSSA and its audit and rate setting contractors must be utilized in the preparation of all Financial Reports for Non-State Owned ICFs/MR and CRFs/DD in accordance with 405 IAC 1-12-3(d). To expedite the rate review process, providers should specifically represent in the cover letter that all deficiencies, adjustments and recommendations contained in the prior period audit report have been corrected and addressed in the preparation of the current financial report. Providers should either represent that the audit findings and adjustments were incorporated into the submitted financial report, or provide sufficient quantitative information to make any adjustments necessary to comply with the audit findings, adjustments and recommendations. Information concerning prior period audit findings should be submitted for each adjustment and recommendation that pertains to the financial report submission.

Generally Accepted Accounting Principles Required Providers are advised that, pursuant to generally accepted accounting principles (GAAP), the Criteria is considered to be a comprehensive basis of accounting. As such, adherence to GAAP is required unless specific Criteria language is to the contrary. Providers should maintain the working trial balance used in completing the forms for each reporting period for a minimum of three years in accordance with 405 IAC 1-12-3(b). The working trial balance should not be submitted unless requested by FSSA and its audit or rate setting contractors. One principle that has great importance in conveying information on the Financial Report for Non-State Owned ICFs/MR and CRFs/DD is full disclosure. In completing the form, attach additional schedules and explanations, where necessary, to accomplish full disclosure. Full disclosure requires that a knowledgeable financial reader, after reviewing the completed forms and attachments, would not be misled. GAAP also requires accurate and consistent classification of financial information. Therefore, providers should exercise care to report all data on appropriate lines and schedules of the form. The reporting of expense amounts on inappropriate lines may tend to be misleading to the financial reader. It is particularly important to record expenses in the correct cost centers and lines when they are subject to limitations in the Criteria.

Attach Explanations Instead of Altering Forms The financial report should not be altered in any way. In the use of unlabeled "other" lines, specify the nature of the item reported. If more space is needed, attach a separate schedule. Do not make two listings on a line or change the description of a line. Column headers may not be modified nor should boxes that have been blacked out on the form be utilized in submitting data. If there are circumstances in which the form does not seem appropriate to report the data in the lines available, please attach a note or schedule to explain. Lengthy or detailed workpapers involving several pages normally should not be submitted with the filing, but should be retained by the provider for future reference, and should be made available when requested by FSSA and its audit or rate setting contractors.

Chain Organizations or Management Groups Non-State Owned ICFs/MR and CRFs/DD that are part of a multiple facility or chain organization that report home office costs must also complete the Home Office Financial Report (Schedules P through W) in accordance with 405 IAC 1-12-3(f). Please refer to the Instructions for the Home Office Financial Report. Allocated costs that are incurred at a home office must be

properly reported on the Home Office Financial Report in order to be included on the Financial Report for Non-State Owned ICFs/MR and CRFs/DD. The Home Office Financial Report must be submitted with all Financial Report for Non-State Owned ICFs/MR and CRFs/DD submissions that include home office costs. For each home office entity allocating costs to individual facilities, only one copy of the Home Office Financial Report should be submitted. Organizations with multiple home office cost allocations should submit a separate Home Office Financial Report for each home office. The cover letter should reference all Non-State Owned ICFs/MR and CRFs/DD facilities affected by the Home Office Financial Report.

SPECIFIC INSTRUCTIONS

While most sections and lines of the financial report form are self-explanatory, the following additional clarification is provided.

Provider Name and Identification Data

Lines 11101 and 11103 -- Type of Report Check the box designating whether this report is an Annual Report or an Historical Report.

Provider Number It is very important that the provider number be stated correctly. The incorrect use of a provider number can result in delays of any rate increase that might be forthcoming. It is also important to enter the provider number on every page of the financial report form.

Lines 20101 and 20102 -- Period of Report Indicate the beginning and ending dates of the financial and statistical data. For Annual Reports, the period of report is twelve (12) months. In those cases involving less than twelve (12) months, ensure that the data reported on the financial report is based on the actual number of days in the period of report.

Certification Statement After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The financial report submitted to the rate setting contractor must contain original signatures. The existence of a preparer shall be considered authorization from the facility for the OMPP and rate setting and audit contractors to discuss the annual financial report and other rate matters with the preparer. Any instructions to the contrary must be in writing from the facility.

Schedule A -- Statistical Data

Lines 141 and 142 -- Beds Available Report the number of beds available for patient or resident care at the beginning and end of the reporting period.

Lines 143 -- Bed Days Available In cases where the number of beds is the same at the

beginning of the period as at the end of the period, total bed days available is the number of beds times the number of days in the reporting period (usually 365 or 366 days for a reporting year). If there was a change in the number of beds during the period, line 143 must be time weighted. Please provide the date of change between beginning beds and the ending beds and other calculations on a separate sheet.

Lines 144 and 148 -- Patient/Resident Days The number of patient/resident days should be based on census logs maintained by the provider. The number of days should be in agreement with applicable data on Schedule I -- Summary of Occupant Days.

Line 153 -- Total Hours Worked During Period The total of all columns on line 153 should equal the total of Schedule E, line 498 column 1. If not, a reconciliation and full explanation must be provided on a separate sheet.

Schedule C -- Schedule of Charges Schedule C should be completed on all financial reports submitted. Columns 1 and 2 should reflect the lowest usual and ordinary charge to private pay residents for like levels of services, facilities and supplies that are covered by the Medicaid per diem rate under the Criteria. Report the private pay rates in effect at the report year end (RYE) in column 1, and at the rate effective date (RED) in column 2. Providers should complete columns 1, 2, 3 and 4. The Current Medicaid rate reported in column 3 should be the Medicaid rate for residential services only.

Schedule D -- Schedule of Revenue Schedule D should disclose all revenues from the facility's operation, and should reconcile to the provider's financial records, including the working trial balance. Routine and ancillary revenues from all payor sources should be reported on the appropriate lines and columns. Income that should be offset against a related expense must also be reported, and question 26810 should be answered at the bottom of Schedule D. Additional disclosures, either through margin notation or a separate schedule should be made to indicate which revenue lines on Schedule D have been offset by the provider on Schedule E.

Routine Daily Service -- Routine daily service revenue should be reported in the appropriate columns as gross revenue by the primary payor source.

Lines 211 through 216 -- Report the routine service revenue on the line representing the level of certification and licensure for this facility. If more than one licensure level for a CRF/DD existed during the reporting period, identify the routine revenue by time period, and report on the lines that apply to the licensure level for each time period.

Schedule E -- Schedule of Expenses

Columns 1, 2 -- Personnel The hours worked column and the personnel cost column relate to salary, wage and contractual amounts paid for services. Hours worked includes continuing education and in-service training time, but does not include vacation, sick and holiday time. Personnel hours are needed to calculate the staffing limitation and to review the reasonableness of expenses. This information should come from the general ledger, actual

payroll time sheets, contractual invoice billings, and/or other records. If an entry is made in either column 1 or 2, there should be a corresponding entry in the other column.

Column 3 -- Other Costs All costs not classified as personnel costs should be entered on appropriate expense lines of column 3. Costs should come from the general ledger. If unlabeled "other" lines are used, specifically identify the nature of the item(s) reported. In general, costs that exceed \$1,000 should be separately identified. If necessary, attach a separate schedule identifying the elements that make up the amount reported on a line.

Column 24 -- Provider Adjustments This column facilitates the removal of non-patient/resident related costs from amounts reported in columns 2 and 3. The column can be used to offset certain revenue items against the related expense. Negative adjustments should be shown in brackets. For example, to remove \$149 of cost from a line write "<149>" in column 24. If an adjustment is made on a line where there are amounts in both columns 2 and 3, it will be presumed that the adjustment pertains only to column 3 -- Other costs, unless a margin notation is made to indicate otherwise. The following are examples of unallowable items that should be eliminated (reduced to zero) in column 24: travel and entertainment to investigate investment or business opportunities and federal income taxes. In addition, the following lines should be eliminated with a negative adjustment in column 24: line 392 Advertising - All Other, and line 398 Contributions and Donations.

If provider adjustments are included in column 24 that pertain to both facility-level expenses and allocated home office costs, then a supplemental schedule that reconciles to column 24, should be attached to the financial report that separately identifies all provider adjustments as either facility adjustments or home office adjustments.

Column 4 -- Total This column is the sum of columns 2, 3 and 24. Only necessary costs required for patient or resident care are to be included in the total.

Columns 5, 8 and 9 -- Allocations The "Allocation Base" column and the columns to the right of it are applicable only to those facilities with more than one level of care, such as a facility that is not fully certified. The "Allocation Base" column should contain the numeric code of the applicable allocation basis from Schedule F. Providers are advised that the rate setting contractor will use the allocation percentages defined by the data in Schedule F and not the actual amount entered in the columns 8 and 9 of Schedule E.

Allocation bases that are acceptable for cost reporting purposes are those bases that are:

- Relevant -- The allocation base must have some significant relationship to the cost report line in question.
- Reliable -- The allocation base must be a faithful representation that is verifiable and unbiased.
- Consistent -- The allocation base must be determined and applied consistently from one period to the next, unless extraordinary circumstances indicate a change to a more

appropriate measure. Changes in allocation basis must be approved by the OMPP or its designee prior to implementation. Requests for changes in allocation bases must be submitted to OMPP for approval at least ninety (90) days prior to the provider's reporting year end.

Lines 341, 342, 343 and 344 -- Laundry and Housekeeping Amounts representing the hours and cost of personnel should be reported in columns 1 and 2 of lines 341 and 342 regardless of whether those services are performed by employees or through contractual arrangements. If contractual services are used, the provider should ask the contractor for documentation of personnel hours and a breakdown between personnel cost and non-personnel costs. If employees are performing duties in more than one department, the actual hours and associated cost in each department should be reported. If accumulating the actual hours and costs in each department is overly burdensome, accurate time studies that cover a two week period in each quarter of the fiscal year may be utilized if fully documented. Other non-personnel costs should be reported on lines 343 or 344, column 3.

Lines 361, 362, 363, 364 and 365 -- Property Costs It is necessary to report interest, depreciation, and lease/rent expense even though the capital return factor will be substituted for these expenses in the Medicaid rate calculation.

Lines 371, 372, 373, 374 and 377 -- Executory Costs Executory costs clearly identified and separable in lease or rent agreements should be reported on the line that is most descriptive. They should not be reported on line 364 (building lease/rent) or line 365 (equipment lease/rent), even if included in rent or lease payment. Examples of executory costs include insurance, repairs and maintenance, and personal property taxes, which should be reported on lines 371, 372 and 374, respectively.

Lines 377 -- Other Ownership Costs Non-Capitalizable costs associated with minor equipment purchases that should be charged to an expense according to the Criteria and are related to patient/resident care, should be reported on line 377.

Lines 381, 382, 383, 384 -- Personnel Costs Subject to Owner, Related Party, Management Limitation Costs associated with personnel that are included in the definition at 405 IAC 1-12-20(a) of owners, related parties, management, consultants who perform management functions, or any individual or entity rendering services above the department head level shall be reported in column 2 of lines 381, 382, 383 or 384. The associated hours worked must be reported in column 1. For full time executive and management personnel, providers may impute hours on the basis of 2080 hours per year, if actual time records are not available. If actual time records are available, they must be used.

The fees and other costs associated with management agreements must be reported on line 383. If the agreement is not a related party transaction, the fees and other costs associated with the management agreement must be reported on line 383, except for personnel costs that may be allocated to specific personnel lines on Schedule E. Costs associated with management agreements that are non-personnel costs must be reported on line 383. The record keeping and reporting requirements necessary to support an allocation of personnel costs to lines other than

line 383 are specified in Provider Bulletin 91-12 dated April 15, 1991. If the management agreement is a related party transaction, the fees and other costs associated with the management agreement must be reported at the cost to the related party management organization.

Lines 385 and 389 -- Personnel Not Subject to Owner, Related Party, Management Limitation
General and administrative personnel that are not included in the definition at 405 IAC 1-12-20(a) shall be reported on line 385 Other Home Office Personnel or line 389 Office and Clerical.

Line 391 -- Legal and Accounting Fees All costs associated with attorney services and accounting services associated with an audit, review or compilation of financial statements should be reported on line 391. All other accounting services normally staffed in-house must be reported on line 385 or 389. Question 49810 must be answered at the bottom of page six (6). If the provider incurs any legal fees, expenses related to expert witnesses, accounting fees, and other consulting fees that were incurred as the result of an administrative or judicial action or proceeding against any agency of the state or federal government, these costs should be identified by Schedule E line and column number as an attachment to the financial report. In accordance with 405 IAC 1-4.3, these costs shall not be reimbursed as reasonably related medical expenses, and should be removed by the provider in column 24.

Lines 392 and 393 -- Advertising All advertising costs, except for help wanted advertising, should be reported on line 392. Reasonable help wanted advertising is an allowable cost and should be reported on line 393. In accordance with 405 IAC 1-12-8(a), except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements, advertising costs are not allowable costs and should be eliminated by the provider in column 24 of line 392.

Line 394 -- Travel Report on line 394 only the reasonable patient/resident-related travel costs of personnel that are not owners. Owner travel that is reasonable and patient/resident-related should be reported on line 405 -- Owner's Expense.

Lines 405 and 416 -- Owner's Expenses Report on these two lines the cost of owner's expenses as defined by the Criteria at 405 IAC 1-12-20(c). There are two lines only as a convenience in preparing data for the form. Generally, the cost of discriminatory employee benefits for owners should be reported on line 416 and all other owner's expenses reported on line 405. Discriminatory employee benefits are those that tend to benefit owners proportionately more than other personnel. The entire cost of the following items that relate to owners should be reported on the applicable line 405 or 416:

1. Travel, entertainment and continuing education
2. Automobile, aircraft, travel and transportation allowances and related costs
3. Employee benefits except benefits available to all employees on a nondiscriminatory basis
4. Cost of life insurance above the amount causing an employee to recognize

- taxable income
5. Employee benefits or expense reimbursements that cause an employee to recognize taxable income

Line 406 -- Consultant Fees In order for an item to be reported on this line, the consultant shall not be included in the definition of owner, related party or management at 405 IAC 1-12-20(a). Line 406 is intended for reporting the cost of independent contractors that are not parties related to the facility, that provide general and administrative services related to patient or resident care that are not normally provided in house by employees of the facility, and where the consultant and consultant's employees lack the ability to implement. No other expense items should be reported on this line. The costs of management agreements should not be reported on line 406, but should be reported on line 383. A detailed listing of consultant fees must be reported in Schedule H.

Lines 411, 412, 413, 414, 415 and 417 -- Employee Benefits Employee benefits should be reported on the line that is most descriptive of the benefit provided. Only benefits that are available to all employees on a nondiscriminatory basis should be reported on the above specified lines. Discriminatory benefits should be reported on line 416.

Line 457 -- Assessment Program Costs Report the amount of provider assessment costs incurred pursuant to 405 IAC 1-12-24(b). Amounts reported on line 457 should be in agreement with assessment amounts that have been transmitted to the State under I.C. 12-15-32-11.

Line 461 -- Day Habilitation Costs Report the total amount of direct day service costs incurred to provide day habilitation services to residents. For facilities that arrange for the provision of day services for its residents from a non-related provider entity, these costs should be supported by an agreement with the day service provider. Do not report indirect or overhead-related costs of the group home, therapy service costs (PT, OT, ST), or transportation costs on this line.

For facilities that arrange for the provision of day services for its residents from a related provider entity, the facility should report the fully allocated actual costs of providing the services to the related entity. However, these costs should exclude the following:

- Workshop raw materials
- Staff wages, payroll taxes and benefits paid with direct staffing grants
- Non-disabled production wages, payroll taxes and benefits
- Consumer wages, payroll taxes and benefits
- Advertising and promotion
- Transportation of finished goods
- Bad debts
- Indirect or overhead-related costs of the group home

The provider must maintain schedules supporting the allocation of day service costs to each facility and submit these schedules upon request by FSSA and its audit and rate setting contractors.

Day service program costs are allowable if the program meets the following criteria.

- The programs have been approved by the Program and Agency Review Committee of the Bureau of Developmental Disabilities Services (BDDS).
- The programs seek and maintain accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF).
- Services provided must be consistent with BDDS day service definitions and guidelines for reimbursement of vocational and habilitation services in effect during the cost reporting period.
- Services must be provided in accordance with the Annual Individual Program/Habilitation Plan (IPP/IHP) for each individual.
- For services provided, documentation must be maintained to reflect an individual's progress toward achievement of annual IPP/IHP goals and objectives.
- Documentation must be maintained to reflect the specific units of service provided to each individual.
- Costs of services reimbursable through Vocational Rehabilitation Services are not allowable costs.

Line 462 -- Day Habilitation Transportation Services Report the costs paid to a day service provider or outside contractor for transporting residents to and from the day service provider. Supporting documentation should be available, upon request by OMPP and its audit and rate setting contractors, to justify utilizing transportation methods other than the facility vehicles.

Schedule F -- Allocation Base Schedule F applies only to those facilities with more than one level of service or those that are not entirely certified. See the additional Schedule E instructions on allocations above. Chain units may, but are not required to, use line 505 if consistent with their approved allocation plan. The methodology used to allocate nursing hours between levels of care should be fully disclosed in an attachment to the financial report.

Schedule G -- Reconciliation of Expenses Generally, the total costs on Schedule E (line 498 column 2 plus column 3) should be equal to the facility's expenses per books and tax returns. However, there may be cases where they are not equal. Any such differences should be disclosed on Schedule G by specific item and amount. If additional space is needed beyond that provided on Schedule G, include an attachment so that the nature of each reconciling item is fully disclosed.

Schedule H -- Consultation Fees Report consultant fees by amount and Schedule E expense line number on this schedule. Note that only fees to unrelated parties may be reported on Schedule H. Transactions with related organizations should be reported on Schedule M. Refer to the instructions for line 406 above.

Schedule I -- History of Bed Changes Provide a history of bed changes in the facility from July 1, 1976 or

date of acquisition, original lease, or construction, whichever is later, until the report year end. The present bed size of the facility should be the sum of entries in column 2, which should also equal the last entry in column 3. If the total of column 3 does not agree with total beds on Schedule A, an explanation of the difference should be attached.

Schedule I -- Room Configuration Provide the bed composition by level of service and type of room as of the reporting year end. All beds of the facility must be included.

Schedule I -- Summary of Occupant Days Census data must be accumulated from accurate census logs of patient/resident population. The method utilized must be sufficient to accommodate the data requirements of this schedule, and providers are encouraged to utilize the Indiana Medicaid Health Care Facilities Daily Census Log available from the rate setting contractor. Since one copy of the form is needed for each level of care per month, providers are asked to reproduce the form locally. Do not send copies of census logs with the financial report unless documentation of census data is requested by the rate setting or audit contractor.

Schedule J -- Analysis of Property The annual financial report should include the historical cost of property at the beginning of period, which should agree with the ending balance on the previous annual report balance. Schedule J of the annual financial report should only contain property additions and disposals that occurred during the provider's reporting year. If any addition or disposal exceeds \$5,000, additional information should be submitted, including: date the asset was placed into service or disposed of, description and purpose of property, location, and cost basis. Major additions amounting to more than five percent (5%) of total property that could qualify for a capital expenditures rate review should only be included on a regular annual rate review if such additions are placed into patient/resident-related service prior to the rate effective date. Property that qualifies for a capital expenditures rate review that is put into patient/resident-related service after the provider's report year end and prior to the rate effective date should be reported on a separate Schedule J, and clearly labeled as to the period to which it covers.

Asset balances (including additions and disposals) of owner expense property defined in 405 IAC 1-12-20© should be included on line 656 -- Owner Expense property. Reimbursement for vehicles is limited pursuant to 405 IAC 1-12-8(b). Refer to Schedule J and the Criteria for appropriate information to be reported regarding vehicle limitations.

The reporting and record-keeping requirements at 405 IAC 1-12-16(a) must be met. If there is any property that is related to other activities and not to patient/resident care, it must be eliminated from Schedule J. In the case of property jointly used for patient/resident care and for other purposes, include the portion related to patient/resident care and attach an explanation and allocation plan. Property acquired from a related party must be restated at the cost to the related party (not to exceed fair market value).

Schedules K and L -- Analysis of Property Financing and Leased Property Identify each financing or leasing component used to acquire or rent patient/resident-related property. This can be done by reviewing the general ledger, financial statements and financing instruments such as leases, mortgage notes and other agreements. Each separate component (e.g., each mortgage, property loan, and lease) should be entered in a

separate column in either Schedule K or L. Do not send the lease, loan or other agreements unless requested by OMPP or its audit or rate setting contractors. Providers should refer to the rate setting contractor's printed work papers, and whenever possible, use the same components and columns that were used in the prior year. If more components exist than there are columns, make extra copies of the form.

Enter the answers to each question in the appropriate space. Many items are dollar amounts or dates. Enter dates in the form MM/DD/YY (month/day/year). Most other questions can be answered with two or three words. If more space is needed, an explanation should be attached. The total of Schedule K, Line 742 should agree with Schedule E, Line 361. The total of Schedule L, Line 777 should agree with Schedule E, Lines 364 and 365. Any exceptions to this should be explained in an attachment. If there is a property financing arrangement or lease agreement that is not entirely for patient/resident-related property, then attach a detailed explanation, including an allocation plan based on the use of the property between patient/resident-related and non-patient/resident related activity.

Line 718 -- Term of Loan-Amortization Period in Months This line refers to the period of time used in determining the amount of debt service payment. For example, if the periodic debt service payment was based on an amortization period of 25 years, enter "300" in line 718 even if the loan is due in 10 years and must be rewritten at that time.

Line 766 -- Leased Property Included in Historical Cost of Patient/Resident Related Property The cost of certain leased property should be included on Schedule J. Property obtained through leases with related parties (line 762 is answered Yes) should be reported on Schedule J at the lower of the cost to the related party or fair market value at the date of lease. Any related lessor's financing associated with the lease property should be reported on Analysis of Property Financing, Schedule K. The cost of property acquired through capital leases with unrelated parties, and any attendant property financing, should also be included on Schedules J and K respectively. No other leased property should be included on Schedules J and K.

Schedule M -- Listing of Owners, Related Parties, and Management All parties with which the provider has conducted transactions during the reporting period that meet the definition of owners, related parties or management personnel and contractors must be reported on Schedule M. List all owners, officers, stockholders and partners with 5% or more ownership interest, even if paid no compensation. Related party definitions are found at 405 IAC 1-12-2(y).

Transactions with related party vendors must be fully disclosed on Schedule M, even if OMPP has granted the provider an exception to the related party requirements. All profits on services, facilities and supplies acquired from related organizations must be identified and removed, except where an exception has been granted by the OMPP under the provisions of 405 IAC 1-12-11. Provider requests for such exceptions must be made to OMPP, or its designee, in advance of the reporting year.

If this facility is involved with a complex capital structure, including providers other than an individual or closely held corporation, attach an explanation including an organizational chart of all ownership interests that is sufficient in scope and clarity to accomplish full disclosure.

Question 89010 must be answered. If the facility is owned by a publicly traded company, the latest annual report to stockholders and Securities and Exchange Commission (SEC) Form 10-K must be attached with the

regular annual rate review submission.

Column 5 Type of Party -- Each individual or organization reported on Schedule M should be identified by type of party: 1, 2, 3 or 4. Refer to the legend on Schedule M.

Column 6 Percent Ownership in the Facility -- Report the percentage of ownership for each owner (on all lines where "1" has been circled in column 5) of this facility. Line 889, column 6 should total 100%.

Column 7 Hours Worked -- For individuals and organizations reported on Schedule M that provide patient/resident-related services, report the hours worked associated with these services. The amounts reported in column 7 should also be reported on the appropriate line of Schedule E, column 1.

Column 8 Amount of Compensation -- Report the compensation of all parties reported on Schedule M. Amounts reported on Schedule E, lines 381, 382, 383 and 384 should be fully disclosed on Schedule M. Compensation of owners and related parties that perform patient/resident-related functions at or below the department head level should be reported in column 8, even though their compensation may be reported on Schedule E lines other than 381 through 384.

Columns 9 and 12 Line on Which Compensation is Reported -- Report the line number on Schedule E on which the compensation or vendor payments were reported.

Column 10 Owner's Expenses -- Report the amount of owner's expenses for each owner. The total for column 10 should agree with the amounts reported on Schedule E, Lines 405 and 416. Refer to 405 IAC 1-12-20 and the specific instructions for lines 405 and 416 above for the applicable requirements.

Column 11 Vendor Payments -- Report the amount of payments to related party vendors or consultants. Related party vendor payments must be reported in column 11 even if OMPP has granted the provider an exception to the related party requirements.

Column 13 Related Party Transaction Profit Removed -- Report whether the profit included in transactions between related party vendors and the provider has been removed from amounts reported on Schedules M and E. If all the profit has not been removed, include sufficient information to identify the total related party transaction profit in a separate attachment. If an exception to the related party rule has been granted by OMPP under the provisions of 405 IAC 1-12-11, indicate the date of the letter from OMPP indicating the exception approval.

Schedule N -- Balance Sheet Report balance sheet information on Schedule N. Account balances should be reported as of the beginning and end of the cost reporting period. In most cases, the beginning of period balances should agree with the end of period balances from the prior year financial report. Any deviations from this should be fully explained in an attachment. General ledger account balances should be summarized on the lines of Schedule N that best describe the nature of the accounts. It is essential that general ledger accounts are summarized on Schedule N in a consistent manner. Amounts reported on unlabeled "other" lines

822, 823 and 848 should be described. Amounts reported on lines 817, 818, 819, 846 and 847 should also be explained. If more space is needed, include the required explanations in an attachment or in the cover letter. Confirm that amounts reported on lines 818 and 819 are not reported on Schedule J; and that amounts reported on line 846 are not reported on Schedule K.

Answer question 80200 indicating the highest level of service provided by an independent accountant regarding the facility financial statements covering the report period. Copies of the financial statements should not be submitted with the Non-State Owned ICF/MR and CRF/DD Financial Report, but should be made available upon request of the Office or its rate setting or audit contractors.

If the provider maintains a separate general ledger for the facility, then report the facility-only balance sheet and owner's equity reconciliation on Schedules N and O, respectively. If the provider does not maintain a separate general ledger for the facility, but instead maintains a combined or consolidated general ledger that includes this facility (i.e., multiple facility or other operations are accounted for with a single general ledger), then do not complete Schedule N or O. In those situations, the provider should submit the balance sheet and owner's equity reconciliation data on the Home Office Financial Report Schedules V and W, respectively. Please refer to the instructions for the Home Office Financial Report before completing those forms.

Schedule O -- Reconciliation of Owners Equity or Fund Balance Schedule O presents the reconciliation of owners equity or fund balance between the beginning and end of the reporting period. The amount reported on line 905 should agree with total revenues reported on Schedule D, and line 920 should agree with total expenses reported on Schedule E. If any of these amounts do not agree, a separate schedule should be submitted to fully disclose the differences. Amounts reported on unlabeled "other" lines 909, 910, 924, 925 and 926 should be fully described. If the space provided in the financial report is not adequate for full disclosure, include the required explanations in a separate schedule or the cover letter.