

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



TO BE USED IN ACCORDANCE WITH THE PROVISIONS OF 405 IAC 1-12
SEE INSTRUCTIONS BEFORE COMPLETING (REV. 12/94)

Round all amounts to nearest whole number or dollar			Provider Number:		
Type of Report: (Check One)			Period of Report		
<input type="checkbox"/> [11101] Annual		<input type="checkbox"/> [11103] Historical Report	[20101] From:		[20102] To:
[12101] Name of Facility			[11301] Employer I.D. Number		
Mailing Address					
[12102] Street or P. O. Box			[12103] City		[12104] State
					[12105] Zip
Physical Address (If Different)					
[12106] Street			[12107] City		[12108] State
					[12109] Zip
[131] Type of Control: (Check One)					[12110] FYE for Tax Reporting
Proprietary For-Profit		Voluntary Non-Profit		Government	
<input type="checkbox"/> [11] Individual <input type="checkbox"/> [12] Partnership <input type="checkbox"/> [13] C Corporation <input type="checkbox"/> [14] S Corporation <input type="checkbox"/> [15] Other (Specify)		<input type="checkbox"/> [21] Church <input type="checkbox"/> [22] Other (Specify)		<input type="checkbox"/> [31] State <input type="checkbox"/> [32] County <input type="checkbox"/> [33] City <input type="checkbox"/> [34] Other	
CERTIFICATION STATEMENT					
<p>This is to certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, complete, and related to patient or resident care. Expenses not related to patient or resident 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.</p>					
Name of Authorized Person		Title/Position		Name of Facility	
Signature of Authorized Person		Date		Telephone Number	
				()	
Name of Preparer		Title/Position		Address of Preparer	
Signature of Preparer		Date		Telephone Number	
				()	

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Round all dollar amounts to nearest whole number or dollar

Provider Number:

SCHEDULE A			
Statistical Data	Line Number	[03] ICF/MR or CRF/DD	[04] Other
Beds Available at Beginning of Period	141		
Beds Available at End of Period	142		
Total Bed Days Available	143		
Total Patient/Resident Days - Medicaid (From Schedule I)	144		
Total Patient/Resident Days - All Patients/Residents (From Schedule I)	148		
Occupancy Percentage (Line 148/Line 143)	151		
Medicaid Utilization (Line 144/Line 148)	152		
Total Hours Worked During Period - (From Schedule E)	153		
Average Hours Worked PPD (Line 153/Line 148)	158		

SCHEDULE B		
<p>[16100] Accounting Method - (Check One) If cash, then submit beginning and ending balance for accounts payable, salaries payable, and inventories on a separate sheet.</p>		
<input type="checkbox"/> (1) Accrual	<input type="checkbox"/> (2) Modified Cash	<input type="checkbox"/> (3) Cash
<p>[16200] Related Party Transactions - (Check One) Does this cost report include any transactions with organizations that are related to the provider, including working capital loans, as defined by the Rate Setting Criteria? If yes, then submit details in a cover letter or on a separate sheet, and report on the appropriate schedules of these forms.</p>		
<input type="checkbox"/> (1) Yes	<input type="checkbox"/> (2) No	

SCHEDULE C						
Schedule of Charges		Line No.	Private Pay		Medicaid	
			[01] at RYE	[02] at RED	[03] Current	[04] Requested
ICF/MR & CRF/DD	All Inclusive	188				

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See instructions before completing

Provider Number:

SCHEDULE D

Schedule of Revenue	Line Number	Medicaid [01]	Other [02]	Total [03]	ICF/MR CRF/DD [04]	Other [05]
Routine Daily Service:						
ICF/MR	211					
Sheltered Living	212					
Intensive Training	213					
Child Rearing	214					
Child Rearing with Behavioral Management	215					
Basic Developmental	216					
Physical Therapy	231					
Speech and Audiology Therapy	232					
Occupational Therapy	233					
Respiratory Therapy	234					
Sale of Medical Supplies	235					
X-Ray and Laboratory	237					
Florist	241					
Barber / Beauty Shop	242					
Vending Machines	243					
Personal Purchases	244					
Meals Sold to Guests and Employees	245					
Day Habilitation Services Revenue	246					
Investment Income - Interest & Dividends	247					
Other Revenue - (Specify)	248					
Less Bad Debt	262	< >	< >	< >	< >	< >
Less Contractual/Charity Allowances	263	< >	< >	< >	< >	< >
Less Other Reductions to Revenue	267	< >	< >	< >	< >	< >
TOTAL	268					

[26810] Have revenues generated from the sale of goods or services to non resident/patients been offset against the cost of such goods and services? (Check one) If no, attach explanation. (1) Yes (2) No

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Round to the nearest whole dollar

Provider Number: _____

SCHEDULE E									
Schedule of Expenses	Line Number	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustments [24]	Total [04]	Alloc. Base [05]	CRF/DD ICF/MR [08]	Other [09]
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 (Specify)	377								
TOTAL OWNERSHIP	378								

**FOR THE MENTALLY RETARDED AND COMMUNITY RESIDENTIAL FACILITIES
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Provider Number:

SCHEDULE E									
Schedule of Expenses	Line Number	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustments [24]	Total [04]	Alloc. Base [05]	CRF/DD ICF/MR [08]	Other [09]
Administrators'/Executive Directors' Salary	381								
Co-Administrators'/Program Directors' 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								
Worker's Compensation	414								
Qualifying Pensions	415								
Owners' Benefits - See Instructions	416								
Other Qualifying Benefits (Specify)	417								
TOTAL EMPLOYEE BENEFITS	418								

Round to the nearest whole dollar

Provider Number: _____

SCHEDULE E

Schedule of Expenses	Line Number	Hours Worked [01]	Personnel [02]	Other [03]	Provider Adjustments [24]	Total [04]	Alloc. Base [05]	CRF/DD ICF/MR [08]	Other [09]
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/Beh. 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								
SUBTOTAL	469								
GRAND TOTAL	498								

[49810] Did any of the following costs that are reported on Schedule E 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 detailed schedule detailing the costs are reported, and include the description and line where these costs were reported.

(1) Yes
 (2) No

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Provider Number:

SCHEDULE F					
Allocation Base	Line Number	Allocation Base Code	Total [01]	ICF/MR or CRF/DD [04]	Other [06]
Square Feet	501	1			
Patient/Resident Days	502	2			
Beds Available	503	3			
Accumulated Costs	504	4			
Home Office Allocation	505	5			
Total Personnel Costs	506	6			
Director of Nursing Hours	507	7			
R.N. Hours	508	8			
L.P.N. Hours	509	9			
Nurses Aides & Orderlies Hours	510	10			
Other (Specify)	511	11			
Other (Specify)	512	12			
Other (Specify)	513	13			
Other (Specify)	514	14			
Other (Specify)	515	15			

SCHEDULE G			
Reconciliation of Expenses	Line No.	Financials or Tax Return [01]	Schedule E [02]
Total Expenses from: (Check Source) <input type="checkbox"/> Financial Statements/General Ledger <input type="checkbox"/> Tax Return	551		
Total Expenses per Schedule E - Line 498 Sum of Columns 2 and 3	552		
Expenses on Financial Statement or Tax Return not on Schedule E Specify	553		
Specify	554		
Specify	555		
Expenses on Schedule E not on Financial Statement or Tax Return Specify	556		
Specify	557		
Specify	558		
TOTAL (columns 1 and 2 should be equal)	559		

SCHEDULE H				
Consultant Fees	List all those who received fees or other compensation for consultation services that are not related parties and are <i>not</i> for management functions as defined at 405 IAC 1-12-20(a). Services from a related party should be reported on Schedule M.			
Name [01]	Line No.	Type of Service Rendered [02]	Schedule E Line No. [03]	Amount [04]
	571			
	572			
	573			
	574			
	575			
	576			
TOTAL	579			

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Provider Number:

SCHEDULE I

History of Bed Changes	Line Number	Date Beds Were Put Into/Removed From Service [01]	Number of Beds Added/Deleted [02]	Total Number of Beds After Change [03]
At later date of original lease, purchase, construction or 7/1/76	135	/ /		
Addition / Deletion	136	/ /		
Addition / Deletion	137	/ /		
Addition / Deletion	138	/ /		
Addition / Deletion	139	/ /		
Total number of beds in this facility at latest report year end	150			

Room Configuration

Type of Room	Line Number	CRF/DD Beds [03]	ICF/MR Beds [04]	Other [05]	Total Licensed Beds [06]
1 Bed - Private	165				
2 Bed	166				
3 or More Beds	167				
TOTAL	169				

Summary of Occupant Days (From Census Logs)	Line Number	Reserve Days [01]	Factor [02]	Adjusted Reserve Days [03]	Present in Facility [04]	Total [05]	Transfer Total in Column 5 to Schedule A	
							Line	Column
Medicaid Days in CRF/DD Beds	191		1/2				144	03
Private Pay & Other	192							
Total CRF/DD Days	193						148	03
Medicaid Days in ICF/MR Beds	194		1/2				144	03
Private Pay & Other	195							
Total ICF/MR Days	196						148	03
Total Days in Other Section	197						148	04
GRAND TOTAL	199							

For Medicaid reserve days, Column 1 times factor in Column 2 is equal to Column 3. For all lines, Column 3 plus Column 4 is equal to Column 5. Column 1 reports occupant days for which a bed is being held but resident/patient is not present in the facility. Column 4 reports occupant days for which resident/patient is actually in the facility for midnight census.

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Provider Number:

SCHEDULE J							
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 E.

[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.	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
[67102] Was any item included in this schedule acquired directly or indirectly from a related party? If yes, attach explanation.	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
[67103] Are the total number of vehicles reported on Line 656 and 657 greater than "one patient/resident 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)?	<input type="radio"/> (1) Yes <input type="radio"/> (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 K, 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.	<input type="radio"/> (1) Yes <input type="radio"/> (2) No

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SCHEDULE K						
Analysis of 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 Patient /Resident Related Property? (Check One) If No, Attach Allocation.	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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Provider Number: _____

SCHEDULE L

Analysis of Leased Property	Line Number	Lease Number 1	Lease Number 2	Lease Number 3	Lease Number 4
ID Number - For Ratesetter Use Only	751				
Name of Lessor	761				
Are Lessor and Lessee Related Parties?*	762	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Description of Leased Property	763				
Does Lease Pertain to Only Patient/Resident Related Property? (Check One) If No, Attach Allocation Plan.	765	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Is the Historical Cost Basis of this Property Included in Schedule J? (Check One)	766	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Does Lease Pertain to Property That is Defined by Criteria as Owners' Expense? Check One)	767	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
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	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Is Lease Payment Contingent Upon Inflation Index or Interest Rate? (Check One) If Yes, Attach Explanation of Contingencies or Methods of Calculation	792	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Has an Independent Accountant Ever Made a Determination as to Type of Lease According to GAAP? (Check One)**	795	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No	<input type="radio"/> (1) Yes <input type="radio"/> (2) No
Indicate Type of Lease in Accordance with GAAP (Check One)**	796	<input type="radio"/> (1) Capital <input type="radio"/> (2) Operating <input type="radio"/> (3) Unknown	<input type="radio"/> (1) Capital <input type="radio"/> (2) Operating <input type="radio"/> (3) Unknown	<input type="radio"/> (1) Capital <input type="radio"/> (2) Operating <input type="radio"/> (3) Unknown	<input type="radio"/> (1) Capital <input type="radio"/> (2) Operating <input type="radio"/> (3) Unknown

* If the answer to Line 762 is "Yes", then report on Schedule J the historical cost basis of patient/resident related property, report on Schedule K the related financing, and complete Schedule L 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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LEGEND: TYPE OF PARTY - Column 5
1. Owner 2. Related-Party 3. Management Personnel 4. Related Vendor

Provider Number: _____

SCHEDULE M													
Listing of Owners, Related Parties, and Management			Mark Type of Party [05]	Percent Ownership in This Facility [06]	Hours Worked [07]	Amount of Compensation [08]	Line on Which Comp. Is Reported [09]	Amount of Owners' Expenses [10]	Amount of Vendor Payments [11]	Line on Which Expense is Reported [12]	Related Party Transactions Profit Removed?		
Line Number	Name, City & State [01]/[02]/[03]	Position / Service or Supply [04]									Yes	No	
											[13]		
871			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
872			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
873			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
874			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
875			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
876			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
877			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
878			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
879			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
880			<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4									<input type="checkbox"/>	<input type="checkbox"/>
889	TOTAL												

[89010] Is this facility owned by a publicly traded company? If yes, attach a copy of the latest Annual Report to Stockholders and SEC Form 10-K.

(1) Yes (2) No

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Provider Number: _____

Round all amounts to nearest whole number or dollar

SCHEDULE N					
Balance Sheet					
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 Resident/Patient 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 - Resident/Patient Related	845				
Property Financing - Not Related to Resident/Patient 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

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

Round all amounts to nearest whole number or dollar

Provider Number:

SCHEDULE O			
Reconciliation of Owners' Equity or Fund Balance			
Beginning of Period Balance (Schedule N, 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 N, Line 859, Column 4)	940		