FINANCIAL REPORT FOR STATE OPERATED NURSING FACILITIES

TO BE USED UNDER PROVISIONS OF 405 IAC 1-17 FOR ALL STATE OPERATED NURSING FACILITIES THAT ARE CERTIFIED AS MEDICAID PROVIDERS BY THE STATE OF INDIANA OFFICE OF MEDICAID POLICY AND PLANNING.	**[11201] Provider Number**

Round all dollar amounts, except per patient day figures, to the nearest whole dollar. Securely attach all worksheets and schedules. **NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may, upon conviction, be subject to fine or imprisonment under Federal or State Law.**

☐ **[11101] Annual Report** ☐ **[11102] Rate Request - Budget** ☐ **[11103] Rate Request - Historical**	**Period of Report**			
	[20101] From:		[20102] To:	
[12101] Name of Facility	**[11301] Federal I.D. Number**			
Mailing Address				
[12102] Street or P. O. Box	**[12103] City**		**[12104] State**	**[12105] Zip**
Physical Address (If Different)				
[12106] Street or P. O. Box	**[12107] City**		**[12108] State**	**[12109] Zip**

SCHEDULE A

Statistical Data	**Line Number**	**[03] State Operated Nursing Facility**	**[06] Other**
Beds available at beginning of period	[141]		
Beds available at end of period	[142]		
Total bed days available	[143]		
Total occupant days - Medicaid - From Schedule M	[144]		
Total occupant days - all patients - From Schedule M	[148]		
Percentage of occupancy (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

[16100] Accounting Method - Check One

☐ (1) Accrual ☐ (2) Modified Cash ☐ (3) Cash

If Cash, submit beginning and ending balances for accounts payable, salaries payable, and inventories on a separate sheet.

[16200] Related-Party Transactions - Were there any transactions, including working capital loans, with organizations related to the provider, as defined by the Rate Setting Criteria? If yes, submit details in a cover letter or on a separate sheet and report on appropriate schedules of this form.

☐ (1) Yes
☐ (2) No

SCHEDULE C

	Schedule of Charges	**Line Number**	**Private Pay**		**Medicaid**		**[05] AGENCY USE ONLY**
			[01] Current	[02] Proposed	[03] Current	[04] Proposed	
NF	All Inclusive Rate	[188]					

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SCHEDULE D

			Provider Number		Period of Report	
					From	To
Schedule of Revenues	**Line Number**	**[01] Medicaid**	**[02] Other**	**[03] Total**	**[06] Nursing Facility**	**[08] Other**
Medicaid Routine Daily Service	[211]					
Physical Therapy	[231]					
Speech and Hearing Therapy	[232]					
Occupational Therapy	[233]					
Respiratory Therapy	[234]					
Sale of Routine Medical Supplies	[235]					
Sale of Non-Routine Medical Supplies	[236]					
X-ray and Laboratory	[237]					
Pharmacy and Drugs	[238]					
Florist	[241]					
Barber/Beauty Shop	[242]					
Vending Machines	[243]					
Personal Purchases	[244]					
Meals Sold to Guests and Employees	[245]					
Activity Sales	[246]					
Investment Income - Interests, Dividends	[247]					
Other Revenue	[248]					
Less Bad Debts	[262]	< >	< >	< >	< >	< >
Less Contractual/Charity Allowances	[263]	< >	< >	< >	< >	< >
Less Other Reductions to Revenue	[267]	< >	< >	< >	< >	< >
TOTALS	[268]					

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SCHEDULE E

								Provider Number	
Schedule of Expenses	**Line Number**	**[01] Hours Worked**	**[02] Personnel**	**[03] Other**	**[24] Provider Adjustment**	**[04] Total**	**[05] Alloc. Base**	**[08] Nursing Facility**	**[10] Other**
Director of Nursing	[311]								
Registered Nurses	[312]								
Licensed Practical Nurses	[313]								
Nurses Aides & Orderlies	[314]								
Medical Director	[315]								
Other Nursing	[316]								
Other Nursing	[317]								
Routine Nursing Supplies	[318]								
Total Nursing	[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 - Movable Equipment	[363]								
Building Lease/Rent	[364]								
Equipment Lease/Rent	[365]								
Insurance (Fire, Property, etc.)	[371]								
Repairs & Maintenance	[372]								
Real Estate Taxes	[373]								
Personal Property Taxes	[374]								
Other Ownership Costs	[377]								
Total Ownership	[378]								

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SCHEDULE E

Provider Number

Schedule of Expenses (Continued)	Line Number	[01] Hours Worked	[02] Personnel	[03] Other	[24] Provider Adjustment	[04] Total	[05] Alloc. Base	[08] Nursing Facility	[10] Other
Administrator's Salary	[381]								
Co-Administrator's Salary	[382]								
Owner, Related-Party, Management	[383]								
Other Home Office Personnel	[385]								
Residential Supervisor	[386]								
House Manager/Parent	[387]								
Qualified Mental Retardation Professional	[388]								
Office & Clerical Personnel	[389]								
Legal & Accounting Fees	[391]								
Advertising - Promotional	[392]								
Advertising - Other	[393]								
Travel Expenses - See Instructions	[394]								
Telephone	[395]								
Licenses, Dues & Subscriptions	[396]								
Office Supplies & Postage	[397]								
Contributions & Donations	[398]								
Interest - Working Capital	[401]								
Utilization Review Costs	[403]								
Liability Insurance	[404]								
Mgmt. Consultant Fees - Schedule H	[406]								
Other General and Administrative	[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]								
Other Qualifying Benefits	[417]								
Total Employee Benefits	[418]								

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SCHEDULE E

								Provider Number	
Schedule of Expenses (Continued)	**Line Number**	**[01] Hours Worked**	**[02] Personnel**	**[03] Other**	**[24] Provider Adjustment**	**[04] Total**	**[05] Alloc. Base**	**[08] Nursing Facility**	**[10] Other**
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]								
TOTAL ROUTINE COSTS	[439]								
Physical Therapy	[441]								
Speech & Hearing Therapy	[442]								
Occupational Therapy	[443]								
Respiratory Therapy	[444]								
Non-Routine Medical Supplies	[452]								
X-ray & Laboratory	[453]								
Florist	[454]								
Barber/Beauty Shop	[455]								
Vending Machines	[456]								
Pharmacy/Drugs	[457]								
Medicare Part D Covered Costs	[458]								
	[459]								
	[460]								
	[461]								
	[462]								
Total Ancillary	[468]								
GRAND TOTALS	[498]								

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SCHEDULE F

				Provider Number	
Allocation Base	Line Number	Allocation Base Code	[01] Total	[04] Nursing Facility	[06] Other
Square Feet	[501]	1			
Patient Days	[502]	2			
Bed Days Available	[503]	3			
Accumulated Cost	[504]	4			
Total Personnel Costs	[505]	5			
Director of Nursing Hours	[506]	6			
R.N. Hours	[507]	7			
L.P.N. Hours	[508]	8			
Nurse Aide Hours	[509]	9			
Non-Routine Medical Supply Revenue	[510]	10			
Physical Therapy Revenue	[511]	11			
Speech & Audiology Therapy Revenue	[512]	12			
Occupational Therapy Revenue	[513]	13			
Respiratory Therapy Revenue	[514]	14			
Other (Specify)	[515]	15			
Other (Specify)	[516]	16			

SCHEDULE G

Reconciliation of Expenses	Line Number	[01] Financials	[02] Schedule E
Total Expenses from Financial Statements	[551]		
Total Expenses per Schedule E - Line 498 Sum of Columns 2 and 3	[552]		
Expenses on Financials not on Schedule E Specify	[553]		
Specify	[554]		
Specify	[555]		
Expenses on Schedule E not on Financials Specify	[556]		
Specify	[557]		
Specify	[558]		
Total ***(Should be equal)***	[559]		

SCHEDULE H

Management Consultation Fees - List all those who receive fees or other compensation for management consultation or related services totaling more than $5,000 in a year. Verify that the consultant organization is not a related party. Services from a related party should be reported on Schedule I.

Line Number	[01] Name	[02] Type of Service	[03] Related Party? Yes	No	[04] Amount
[571]			☐	☐	
[572]			☐	☐	
[573]			☐	☐	
[574]			☐	☐	
[575]			☐	☐	
[576]			☐	☐	
[579]	**Total** ***(Should agree with Line 406)***				

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SCHEDULE I

LEGEND: TYPE OF PARTY - COLUMN [05]: 1. RELATED PARTY 2. MANAGEMENT 3. RELATED VENDOR

Provider Number

Line No.	Listing of Related Parties and Management: [01]/[02]/[03] Name, City & State	[04] Position / Service or Supply	[05] Type of Party	[06] Hours Worked	[07] Amount of Compen-sation	[08] Line on Which Comp. Is Reported	[09] Amount of Vendor Payments	[10] Line on Which Expense is Reported	[11] Related Party Transactions Profit Removed? Yes	No
[601]			1 2 3						Yes	No
									Profit $	
[602]			1 2 3						Yes	No
									Profit $	
[603]			1 2 3						Yes	No
									Profit $	
[604]			1 2 3						Yes	No
									Profit $	
[605]			1 2 3						Yes	No
									Profit $	
[606]			1 2 3						Yes	No
									Profit $	
[607]			1 2 3						Yes	No
									Profit $	
[639]	**Total**									

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SCHEDULE J

	Provider Number

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

* Please submit detailed information for any addition or disposal in excess of $5,000 including: date placed into 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.

Does any item included in this schedule pertain to any property that is not patient related to beds listed in Schedule A? [66500] ☐ (1) Yes ☐ (2) No

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SCHEDULE K

					Provider Number	
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]					
Original Commitment Date of Loan	[716]					
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]	(1) Fixed (2)	(1) Fixed (2)	(1) Fixed (2)	(1) Fixed (2)	(1) Fixed (2)
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 Any Property that is Not Patient Related to Beds Listed in Schedule A?	[748]	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No

SCHEDULE L

Analysis of Leased Property	**Line Number**	**Lease Number 1**	**Lease Number 2**	**Lease Number 3**	**Lease Number 4**	**Lease Number 5**
ID Number - For Ratesetter Use Only	[751]					
Name of Lessor	[761]					
Does Lease Pertain to Any Property that is Not Patient Related to Beds Listed in Schedule A?	[765]	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No
Is the Historical Cost Basis of this Property Included in Schedule J?	[766]	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No	(1) Yes (2) No
Date of New or Renegotiated Lease this Period	[767]					
Inception Date of Original Lease Agreement	[775]					
Amount of Lease Payments this Period Without Executory Costs	[778]					
Line Number on which Expense is Reported	[779]					

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SCHEDULE M

							Provider Number	
Summary of Occupant Days from Census Logs	**Line Number**	**[01] Reserve Days**	**[02] Factor**	**[03] Adjusted Reserve Days**	**[04] Present in Facility**	**[05] Total**	**Transfer Total in Column 5 to**	
							Line	**Column**
Days in Nursing Facility Beds Medicaid	[801]		1/2				144	03
Private Pay & Other	[802]							
Total Nursing Facility Days	[805]						148	03
Total Other Days	[811]						148	06
Grand Total	[815]							

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 Occupant days for which a bed is being held but resident is not present in the facility.

Column 4 Occupant days for which resident is actually in facility for midnight census.

[81800] Were there any changes in licensed or certified beds during this period? If yes, attach explanation. ☐ (1) Yes ☐ (2) No

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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 patient care. Expenses not related to 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 that 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.

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**
		( )