



Home Office

FINANCIAL REPORT FOR NURSING FACILITIES

TO BE USED IN ACCORDANCE WITH THE PROVISIONS OF 405 IAC 1-14.6

SEE INSTRUCTIONS BEFORE COMPLETING (REV. 1/06)

See Instructions before completing

Name of Home Office:			
Report Type:	<input checked="" type="checkbox"/> Annual Report	Period of Report:	From: To:
Home Office Mailing Address:			
[12110] Street or P. O. Box	[12111] City	[12112] State	[12113] Zip
Home Office Physical Address:			
[12114] Street or P. O. Box	[12115] City	[12116] State	[12117] Zip
SCHEDULE P			
Line No.	Schedule of Home Office Expense		
1	Total unadjusted Home office expenses per Attached Statement of Expenses which agrees to either the Income Statement or the General Ledger		
Adjustments:			
2	Services the Office of Medicaid Policy and Planning pays for separately or by other programs		
3	Travel not related to patient care		
4	All advertising other than help wanted		
5	Legal, Accounting, and Consulting Fees not related to 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.		

Home Office

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Name of Home Office:

SCHEDULE Q

Home Office Allowable Expense Allocation

Line No.	AIM Number [01]	Facility Name or Location [02]	Allocation Base [03]	Allocated Home Office Expense Line 498, Schedule R [04]
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22	Total Allocation Basis			
23	TOTAL		(Should Agree with Line 13 of Schedule P)	

Home Office

FINANCIAL REPORT FOR NURSING FACILITIES

Round to the nearest whole number or dollar

Name of Home Office: _____

SCHEDULE R									
Schedule of Allowable Home Office Expenses	Line No.	Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)	
		AIM Number		AIM Number		AIM Number		Hours Worked [07]	Costs [08]
		Hours Worked [01]	Costs [2]	Hours Worked [03]	Costs [4]	Hours Worked [05]	Costs [6]		
Director of Nursing	311								
Registered Nurses	312								
Licensed Practical Nurses	313								
Nurses Aides and Orderlies	314								
Medical Director	315								
Other Nursing	316								
Pool Nursing	317								
Routine Medical Supplies	318								
Non-Routine Medical Supplies	319								
Parenteral and Enteral Nutrition (PEN)	320								
NATCEP Costs	321								
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								
Repairs and Maintenance	353								
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								
Real Estate Taxes	373								
Personal Property Taxes	374								
Other Capital Costs (Specify)	377								
TOTAL OWNERSHIP	378								

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SCHEDULE R

Schedule of Allowable Home Office Expenses		Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)		
		AIM Number		AIM Number		AIM Number				
		Line No.	Hours Worked [01]	Costs [2]	Hours Worked [03]	Costs [4]	Hours Worked [05]	Costs [6]	Hours Worked [07]	Costs [08]
Administrator's Salary	381									
Co-Administrators' Salary	382									
Owner, Related Party, Management	383									
Directors' Fees	384									
Other Home Office Personnel	385									
QMRP	388									
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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SCHEDULE R									
Schedule of Allowable Home Office Expenses		Facility Name		Facility Name		Facility Name		TOTAL COST (Should Agree with Line 13 of Schedule P)	
		AIM Number		AIM Number		AIM Number			
		Hours Worked [01]	Costs [2]	Hours Worked [03]	Costs [4]	Hours Worked [05]	Costs [6]		
		Line No.							
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								
Physical Therapy	441								
Speech and Audiology Therapy	442								
Occupational Therapy	443								
Respiratory Therapy	444								
TOTAL THERAPY SERVICES	448								
TOTAL ROUTINE COSTS	450								
X-Ray	453								
Laboratory	454								
Florist	455								
Barber/Beauty Shop	456								
Vending Machines	457								
Nursing Facility Quality Assessment Fees	460								
Pharmacy/Drugs	461								
Ambulance	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 these costs are reported. (1) Yes (2) No

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SCHEDULE S

Analysis of Property	Line No.	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 additional disposal in excess of \$5,000 including: date placed in service or disposed of, 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 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

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SCHEDULE T

Analysis of Property Financing	Line No.	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, Average Interest Rate at End 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 Related Property? (Check One)	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

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Name of Home Office:

SCHEDULE U					
Analysis of Leased Property	Line No.	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	<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 Leased Property	763				
Does Lease Pertain to Only Patient Related Property? (Check One) If No, Attach Allocation Plan.	765	<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
Is the Historical Cost Basis of this Property Included in Schedule S? (Check One)	766	<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
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="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
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="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
Has an Independent Accountant Ever Made a Determination as to Type of Lease According to GAAP? (Check One)*	795	<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
Indicate Type of Lease in Accordance with GAAP (Check One)*	796	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown	<input type="checkbox"/> (1) Capital <input type="checkbox"/> (2) Operating <input type="checkbox"/> (3) Unknown

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

Assets	Line No.	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 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 Related	845				
Property Financing - Not Related to 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

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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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Name of Home Office:

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 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.

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
		()