

# **INSTRUCTIONS FOR FINANCIAL AND STATISTICAL REPORT – FORM MA-11**

## **GENERAL INSTRUCTIONS**

These instructions are for use in the preparation of the standard file and completion of the Certification Report used to file Form MA-11 (cost report), the Financial and Statistical Report for Nursing Facilities and Services under the Medical Assistance (MA) Program of the Department of Public Welfare, Commonwealth of Pennsylvania. The term “standard file” denotes either the standard text file in the format specified in the MA-11 Cost Report Submission System End User Manual or the standard spreadsheet file that can be downloaded from the MA-11 Cost Report Submission System intra/internet site. Instructions for completing the standard spreadsheet file may be found in the MA-11 Cost Report Submission System End User Manual.

The MA-11 will be used by all facilities approved as a General Nursing Facility, Hospital-Based Nursing Facility, Special Rehabilitation Facility, or a County Nursing Facility. If applicable, instructions for completing each schedule of the MA-11 are provided. These instructions are not intended to be comprehensive. In completing the MA-11, providers should refer to 55 Pa Code Chapter 1187 as a guide in identifying allowable costs. County facilities should also refer to Chapter 1189. In addition, the results of prior audits by the Department should be considered in the preparation of the cost report.

The MA-11 must be based on financial and statistical records maintained by the facility. These records must be detailed, orderly and complete and available for audit. Providers are required to retain the supporting financial and statistical documentation for a minimum of four years.

## **COMPLETION OF SCHEDULES**

All schedules must be fully completed. Failure to properly complete a schedule may result in rejection of the standard file. A standard file will be rejected and will not be considered acceptable if it does not meet the criteria set forth in the MA-11 acceptability validations in the MA-11 Cost Report Submission System End User Manual.

Unless specifically stated otherwise, facilities may not provide substitute schedules. However, exhibits providing supportive additional information are encouraged. One principle that has great importance in conveying information on these forms is full disclosure. Full disclosure requires that a knowledgeable financial reader, after reviewing the completed forms and attachments, would not be misled.

Report all data in the appropriate areas of the standard file. If you use an unlabeled “other” line, identify the reported item or service. Do not use “See attachment” or similar terms in the standard file. If you are unable to key the actual line number and/or amount in the standard file, submit a separate schedule with the Certification Report. For example, an Adjustment to Expenses on Schedule E may apply to several Schedule C line numbers. On Schedule E the total amount of the adjustment should be listed in Column A and verbiage such as “Separate Schedule” should be noted in Column B. A separate schedule must then be mailed with the Certification Report detailing the breakdown of the amount by line number. The schedule must be labeled by the title and line number and the name of this separate schedule must be listed in the Additional Supporting Documents area.

If more space is needed for Schedules J and K, attach a separate paper schedule to the Certification Report that lists only the additional items not included in the standard file.

The standard file does not allow two entries on a line, changing the name of a line, or changing a line label or column heading.

Round dollar amounts to the nearest whole dollar by increasing any amount of \$.50 or more to the next higher dollar. All per diem amounts should be rounded to two decimal places, and all percentages should be carried to four decimal places.

## COMPLETION OF CERTIFICATION REPORT

The Certification Report for a submitted standard file is generated by the MA-11 Cost Report Submission System and posted in the provider's directory upon submission of a valid file. See the MA-11 Cost Report Submission System End User Manual for instructions on printing the Certification Report. Do not substitute or mail these instructions or the Certification Schedule with the Certification Report.

The Certification Report is divided into the five areas described below. Each provider's Certification Report will be specific to the data submitted in the valid cost report file.

### **Administrator/Preparer Signature and Contact Person:**

**Administrator's Signature** - This area must be completed on the Certification Report by all providers as certification of the valid data submitted to the MA-11 Cost Report Submission System and the exhibits, schedules, forms, and explanations mailed with the Certification Report. Each copy of the Certification Report must have an original signature (no photocopies or facsimiles) of an authorized officer or administrator of the facility. The telephone number, fax number and e-mail address must be the contact information for the responsible officer or administrator.

**Contact Person** – The person designated as the contact will be notified if additional information is needed for the cost report acceptance process or audit. The designated contact person is authorized to resolve all concerns regarding the facility cost report. If the contact person cannot be reached, the facility officer or administrator will be contacted.

**Preparer's Signature** - This area must be completed on the Certification Report by providers whose valid cost report file indicated a preparer's name on the Certification Schedule, Part IV, line 4a. If no preparer was indicated, the statement preceding the signature line will state "Preparer reported on the Certification Schedule, Part IV, line 4a is **BLANK**." In this instance, no preparer's signature is required. If the statement contains a name rather than **BLANK**, the preparer's signature area and date must contain an original signature on all copies of the Certification Report.

The Administrator/Preparer Signature and Contact Person area will appear as follows on the Certification Report:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I hereby certify that I have read the above statement and that I have examined the Cost Report data in file MAXXXXXXXXXXXXXX.XXXXXXXXXXXXXX including any attached exhibits, schedules, forms, and explanations to this Certification Report and found these to be true, accurate, and complete. Expenses not related to nursing facility resident care have been appropriately identified or removed. I understand that this information is submitted for the purpose of developing payment rates under the Pennsylvania Medical Assistance 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. I authorize the contact person designated below to resolve all issues regarding the cost report acceptance process or audit.

FACILITY OFFICER OR ADMINISTRATOR: \_\_\_\_\_  
(signature)  
\_\_\_\_\_  
(print name)

DATE: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
FAX NUMBER: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_

Contact Person reported on the Certification Schedule, Part III, line 3a is **JOHN DOE**.

CONTACT'S TITLE: \_\_\_\_\_  
CONTACT'S EMPLOYER: \_\_\_\_\_  
TELEPHONE NUMBER: \_\_\_\_\_  
FAX NUMBER: \_\_\_\_\_  
E-MAIL ADDRESS: \_\_\_\_\_

Preparer reported on the Certification Schedule, Part IV, line 4a is **JOHN DOE**.

PREPARER'S SIGNATURE: \_\_\_\_\_  
DATE: \_\_\_\_\_

**Private Pay Rate Signature:** This area must be completed on the Certification Report by providers whose valid cost report file indicated "NO" on Schedule MA-58, Part I, line 1a. If the item was answered "YES", this area will appear as "NO SIGNATURE REQUIRED". If a signature is required, this area will appear as follows:

Schedule MA-58, Part I, line 1a is **“NO”** (MA rate does not exceed private pay rate).

I hereby certify that the facility’s usual and customary charges to the general public for a room during this reporting period exceeded the facility’s Medical Assistance rate to the Department. I understand that any false claims, statements, or concealment of material fact may be prosecuted under applicable federal or state law. I understand that if I do not sign this statement, the Department will make any necessary gross adjustments to the facility’s reimbursement in accordance with 62 P.S. §1406(b).

FACILITY OFFICER OR ADMINISTRATOR: \_\_\_\_\_

DATE: \_\_\_\_\_

**Medicare Rate Signature:** This area must be completed on the Certification Report by providers whose valid cost report file indicated a Medicare rate on Schedule MA-58, Part II, line 2a. If no Medicare rate was encoded, this area will appear as “NO SIGNATURE REQUIRED”. If a Medicare rate was encoded, this area will appear as follows:

Schedule MA-58, Part II, line 2a is **\$XXX.XX**.

I hereby certify that the above Medicare per diem rate was/would have been the average Medicare rate as determined by the instructions to Schedule MA-58 for any Medicare resident had that Medicare resident been provided services during the MA-11 report period. I understand that any false claims, statements, or concealment of material fact may be prosecuted under applicable federal or state law.

FACILITY OFFICER OR ADMINISTRATOR: \_\_\_\_\_

DATE: \_\_\_\_\_

**Required Supporting Documents:** This area is used to identify all required supporting documents that must be mailed with the Certification Report in order for your cost report to be acceptable. The following list of supporting documents contains all possible documents that may be required. However, your Certification Report will list only those documents required as a result of data submitted in your valid standard file. A sample of this area of your Certification Report appears as follows:

One **legible** copy of these documents must be mailed with your completed Certification Report in order for your cost report to be acceptable. Arrange the documents in the same order as listed and label the first page of each supporting document as indicated by the title.

Organization Chart - Organization chart of supervisory personnel with names of personnel included.

Certification Schedule, PART II, line 2a – If your facility is affiliated with another entity through ownership, management or contractual agreement attach a listing of the components of the entire entity. If the entity files a Medicare Home Office cost report, the Medicare Home Office report and the intermediary audit report with adjustments must be submitted with the MA-11, at audit, or when available.

Sch. C, line 31 - Documentation to support an entry of other than blank or zero on Schedule C, line 31, column G.

1. Include copies of the tax notices, which identify the type of tax and taxing authority, the location and description of the property, the tax period and the tax amount.
2. **Submit proof of any and all payments (even if partial payments) to the taxing authority in the form of copies of receipted bills, cancelled checks (front and back) or verification from taxing authority on letterhead which includes tax period, location of property, amount paid, date paid and signature.**
3. Reasonable payment made in lieu of real estate taxes must be supported by proof of payment. A copy of the agreement with the taxing authority must also be provided.
4. Submit a schedule reconciling the tax notices to the amount reported on Schedule C, line 31 to include rebates and refunds of real estate taxes and amounts paid and/or unpaid to date.

Sch. C, line 32 - Schedule to support an entry of other than blank or zero on Schedule C, Line 32

1. Include major movable property purchased item additions and deletions including date of acquisition, description of property, number of units, unit acquisition cost, and total acquisition cost.
2. Include major movable property purchased item deletions including date of deletion, number of units, description of property, original acquisition cost, date of acquisition, American Hospital Association (AHA) Life, and proceeds from sale or disposal, remaining book value, and total offset. .

3. Include major movable property rented and leased items including term of rental or lease (to and from dates), description of property, imputed purchase price, AHA Life, annual straight-line (SL) depreciation, annual lease or rental payments and reported amount.

Suggested format for supporting documentation of major movable property is located on Pennsylvania's MA-11 Cost Report Submission System website: <http://www.pama11.com/downloads/SchCLine32.XLS>.

Sch. C, line 40, Column A – Schedules to support an entry of other than blank or zero on Schedule C, line 40.

1. Submit a reconciliation of the gross wages reported on the MA-11 to the gross wages reported on the four (4) PA UC-2 (or 941) tax forms, by quarter, along with copies of the summary page of the PA UC-2 tax returns showing gross wages for each quarter of the cost report year.
2. Submit copies of the summary page of each payroll register showing gross wages for each pay period during the cost report year, including those payroll registers used in computing the accrued wages at beginning and end of year. If the payroll registers do not clearly show the pay period ending date and pay date, handwrite those dates on the copies.
3. Submit a schedule showing inter-company transfers of employees between facilities, if applicable. This schedule should show the employees' names, the dates of transfer, the employees' wage rates at the time of transfer, and the hours worked at each facility.
4. Submit a schedule of fringe benefits related to inter-company transfer of employees.
5. Submit the computations for the beginning and ending accrual of wages included in the cost report wages.

Suggested format for salary reconciliation is located on Pennsylvania's MA-11 Cost Report Submission System website: <http://www.pama11.com/downloads/SchCLine40ColumnA.XLS>.

Sch. C, Column J - Schedule to support an entry > 0.0000 on any line, Column J. The documentation should enable allocated expenses to be traced from the facility General Ledger to the cost report. See instructions to Schedule C for the correct format.

Sch. D, line 10- Schedule to support an entry of other than blank or zero on Schedule D, Line 10, Column A. Indicate the source, the amount, and where the related Schedule C expenses appear. Attach copies of invoices paid with the Exceptional DME Grant.

Sch. D, line 19 - Schedule to support income greater than \$500 reported on Schedule D, line 19. Indicate the source, the amount, and where the related Schedule C expenses appear.

Sch. D, line 20 - Schedule to support income greater than \$500 reported on Schedule D, line 20. Indicate the source, the amount, and where the related Schedule C expenses appear.

Sch. D, line 21 - Schedule to support income greater than \$500 reported on Schedule D, line 21. Indicate the source, the amount, and where the related Schedule C expenses appear.

Sch. E, line 1 - Schedule to support costs reported on Schedule E, column A, line 1.

Sch. E, line 13 - Schedule to support costs reported on Schedule E, column A, line 13.

Sch. E, line 14 - Schedule to support costs reported on Schedule E, column A, line 14.

PPE - Schedule of additions and deletions to property, plant, and equipment to support the difference in costs submitted on Schedule L, column A, line 11 and Schedule L, column B, line 11. For additions, include item description; date acquired, cost or other depreciable basis, current annual depreciation, and life and method of computing depreciation.

Loan Schedule – Classified loan schedule to support costs submitted on Schedule G, line 12. It should include the name of the lender, purpose of the loan, period of the loan, interest rate, interest expense and balance of the loan at the end of the report period.

Sch. G, line 19 - Schedule to support costs greater than \$1,000 reported on Schedule G, line 19.

Sch. I, line 2 – Schedule to support number of meals served on lines (2a) through (2g). The schedule should include headings for the meals served categories listed on Schedule I questions (2a) through (2f) on one axis and time (months or weeks), on the other axis with category totals. **Resident days times three is not a valid calculation to support the number of meals served.**

Sch. I, line 4 - Schedule to support response of "YES" to capital assets with an acquisition cost of \$500 or more that have been expensed in net operating costs on Schedule I, line 4.

Sch. I, line 5 - Schedule to support response of "YES" to administrative cost allocated to other cost center on Schedule I, line 5. Show cost category, basis of allocation, and amount allocated for each line item.

Sch I, line 6 – Shared costs must be allocated per Schedule C instructions.

Sch. I, line 11 - Schedule of related parties to support response of "YES" on Schedule I, line 11. Identify the name, title and/or function, number of hours worked per week, salaries/wages, fringe benefits, and line of Schedule C on which this is recorded.

Sch. I, line 12 - Schedule of specific details of personal expenses to support response of "NO" on Schedule I, line 12. Include amounts and the Schedule and line on which this is recorded.

Sch. I, line 13 - Schedule of details of advances to officers attached to support response of "YES" on Schedule I, line 13. Identify to whom, amount, and interest during the report period.

Sch. I, line 14 - Schedule of details of advances from officers to support response of "YES" on Schedule I, line 14. If these details have been included on the Classified Loan Schedule, the supporting document for Schedule I, line 14 should state the location of these details.

Sch. K - Schedule to support all transactions between the facility and the related business. The schedule must show the calculation used to determine the amount of profit entered in Column C even if the profit is zero. The schedule should also include any additional lines greater than 14 needed to complete the information for the facility. See Schedule K examples at <http://www.pama11.com/downloads/schedulek.doc>.

Sch. L, line 30 - Schedule to support other R/E account transactions on Schedule L, line 30.

Sch. MA-58, line 2a - Schedule to support Medicare rate submitted for Schedule MA-58, Part II, line 2a. See instructions to Schedule MA-58 for the correct format.

Trial Balance - Combining detail trial balance showing all general ledger account ending balances. It must indicate the groupings of accounts to agree to the line item totals reported on Schedules C and D.

Financial Statements - Facility-specific financial statements to support a response of "NO" to "Schedule L Completed?".

Sch. 1189-B, Line 4 - Schedule to support the loss on the sale of fixed and movable assets recorded on Schedule 1189-B, Line 4, Column A.

Sch. 1189-B, Line 5 - Schedule to support an entry of other than blank or zero on 1189-B, Line 5, Column A.

Sch. 1189-B, Line 6 - Schedule to support an entry of other than blank or zero on 1189-B, Line 6, Column A.

Sch. 1189-B, Line 7 - Schedule to support an entry of other than blank or zero on 1189-B, Line 7, Column A.

Sch. 1189-B, Line 12 - Schedule to support an entry of other than blank or zero on 1189-B, Line 12, Column A.

Sch. 1189-B, Line 13 - Schedule to support an entry of other than blank or zero on 1189-B, Line 13, Column A.

Sch. 1189-B, Line 14 - Schedule to support an entry of other than blank or zero on 1189-B, Line 14, Column A.

Sch. 1189-B, Line 15 - Schedule to support an entry of other than blank or zero on 1189-B, Line 15, Column A.

**Additional Supporting Documents:** This area is used to identify all supporting documents that must be mailed, if applicable, with the Certification Report, or as soon as they are available to the facility. A sample of this area of your Certification Report appears as follows:

One **legible** copy of these documents must be mailed with your completed Certification Report, if they are applicable to the facility. Arrange the documents in the same order as listed and label the first page of each supporting document as indicated by the title. On the blank lines, list any other supporting document necessary to provide additional information for full disclosure. Label the documents and include one copy with your Certification Report.

Independent Accountant Report – Submit an Independent Accountant Report, if applicable.

Medicare Intermediary Audit Report – Submit a Medicare Intermediary Audit Report, if applicable.

Medicare Report – Submit a Medicare Report, if applicable. If not completed at time of filing, the Medicare report must be mailed when completed.

Medicare Home Office Report – If the entity files a Medicare Home Office cost report, the Medicare Home Office report and the intermediary audit report with adjustments must be submitted with the MA-11, or as soon as each is available.

Financial Statements – Facility-specific financial statements, if available.

Participation Review Exception Request - Submit a copy of any approvals received under 55 Pa. Code §1187.21a (relating to nursing facility exception requests-statement of policy).

Replacement Beds - Submit a copy of any approvals received under 55 Pa. Code §1187.113a (relating to nursing facility replacement beds-statement of policy), if not previously submitted with a prior cost report.

Terminated Beds - Submit a copy of any termination notices received under 55 Pa. Code §1101.77a (relating to termination for convenience and best interest of the Department – statement of policy), if not previously submitted with a prior cost report.

Allocation Letter - Letter from the Department signifying that an allocation basis other than “actual” or preprinted allocation is acceptable for Schedule C, column K.

Sch. C, line 15 – Submit documentation to support beauty and barber policies.

1. Submit the written policy that identifies all routine and non-routine beauty and barber services provided by the facility.
2. Submit a list of the fees charged by the facility for each routine or non-routine beauty or barber service.
3. Submit documentation that explains the facility’s computation of the routine and non-routine beauty and barber costs reported on line 15.

Routine services are defined by each facility and are available to MA residents at no charge. The facility expense for all routine services, regardless of payor type, is allowable. Non-routine services include any additional or supplemental services for which an MA resident can be charged. The expenses for these services are then considered non-routine for all residents in the facility regardless of payor type. The facility expense for all non-routine service is not allowable. If routine and non-routine beauty and barber expense cannot be identified or is not supplied, beauty and barber revenue (net of any contractual adjustments) will be offset up to the total expense amount.

Sch. E, Column B - Schedule to support more than one Schedule C Line Number for any Schedule E lines other than 1, 13 or 14.

Sch. E, line 16 - Schedule to support expenditures in excess of the Exceptional DME Grant.

Sch. J - Schedule to support any additional lines greater than 15 needed to complete the information for the facility.

## **COST REPORT FILING**

Annual MA-11 cost reports shall be filed with the Department within 120 days following the close of a fiscal year of June 30 or December 31. The MA-11 receipt date recognized by the Department for the filing of the MA-11 is the date the Certification Report Package is received at the address noted at [www.PAMA11.com](http://www.PAMA11.com), under Points of Contact, or is the date the Certification Report Package is date-stamped as received by the Rate Setting Division, as of close of business at 5 P.M. A postmark date is not the receipt date. Failure to file an acceptable cost report within the required time limits may result in the termination of the nursing facility's provider agreement and will result in adjustment of the nursing facility's per diem rate. (See 55 Pa Code §1187.80). This cost report must cover a prior fiscal year period of twelve consecutive months. Facilities beginning operations during the fiscal period will prepare a report from the date of approval for participation in the MA Program to either June 30 or December 31. Facilities with a change of ownership during the fiscal period will prepare two reports: a final report submitted by the entity selling the facility for the period of the fiscal year that the entity owned the facility and a report submitted by the entity buying the facility for the period of the fiscal year that the new entity owned the facility.

A nursing facility that enters into a termination agreement or an agreement of sale, or is otherwise undergoing a change of ownership or is withdrawing or being terminated as a nursing facility, shall file an acceptable final MA-11 cost report as well as outstanding annual cost reports with the Department within 90 days of the effective date of the termination, transfer, withdrawal, or change of ownership. (See 55 Pa Code §1187.75).

The successful filing of the MA-11 includes completion and submission of a valid standard file, completion of the Certification Report that is generated as a result of the submission of a valid standard file, and the receipt by the Department of the completed Certification Report and all required attachments and supporting documents.

Mail or deliver two copies of the Certification Report with original signatures and one copy of the supporting documents to the address located on the Certification Report and [www.PAMA11.com](http://www.PAMA11.com), under Points of Contact.

**FINANCIAL AND STATISTICAL REPORT FOR  
NURSING FACILITIES AND SERVICES  
UNDER THE MEDICAL ASSISTANCE PROGRAM OF THE  
DEPARTMENT OF PUBLIC WELFARE  
COMMONWEALTH OF PENNSYLVANIA**

<b>Certification Schedule</b>
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<b>PART I. COST REPORT AND FACILITY INFORMATION</b>					
<b>LINE NO.</b>	<b>DESCRIPTION</b>	<b>RESPONSE</b>			
(1a)	LOGIN ID				
(1b)	TEST (T or F)				
(1c)	FACILITY NAME				
(1d)	MA NO.				
(1e)	REPORT BEGIN DATE				
(1f)	REPORT END DATE				
<b>PART II. FACILITY AFFILIATION INFORMATION</b>					
<b>LINE NO.</b>	<b>QUESTION</b>	Code YES as "1"; NO as "0"		<b>YES</b>	<b>NO</b>
(2a)	Is your facility affiliated with another entity through ownership, management or contractual agreement? If "YES", attach a listing of the components of the entire entity.				
(2b)	If "YES", name the entity: Home Office _____ Management Company _____ Other Controlling Entity _____				
(2c)	Is this a change from the last cost reporting period?				
<b>PART III. CONTACT PERSON'S INFORMATION</b>					
<b>LINE NO.</b>	<b>QUESTION</b>				
(3a)	CONTACT PERSON'S NAME:				
(3b)	CONTACT PERSON'S TITLE:				
(3c)	CONTACT PERSON'S EMPLOYER:				
(3d)	CONTACT PERSON'S TELEPHONE NUMBER:				
(3e)	CONTACT PERSON'S FAX NUMBER:				
(3f)	CONTACT PERSON'S E-MAIL ADDRESS:				
<b>PART IV. PREPARER INFORMATION</b>					
<b>LINE NO.</b>	<b>QUESTION</b>				
(4a)	COST REPORT PREPARED BY (if Other than Facility):				
(4b)	PREPARER'S FIRM NAME (If applicable):				
(4c)	FIRM TELEPHONE NUMBER:				
(4d)	FIRM FAX NUMBER:				
(4e)	PREPARER'S E-MAIL ADDRESS:				
<b>PART V. CERTIFICATION STATEMENT (Facility Officer or Administrator and Preparer (if applicable) must sign this statement on the Certification Report.)</b>					
<b>MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.</b>					
<b>CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S):</b>					
I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report data in file (file name), including any attached exhibits, schedules, forms, and explanations and found these to be true, accurate, and complete. Expenses not related to nursing facility resident care have been appropriately identified or removed. I understand that this information is submitted for the purpose of developing payment rates under the Pennsylvania Medical Assistance 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. The designated contact person is authorized to resolve all concerns regarding the facility cost report acceptance process or audit.					
<b>PART VI. MEDICARE INTERMEDIARY</b>					
<b>LINE NO.</b>	<b>QUESTION</b>				
(6a)	NAME OF MEDICARE INTERMEDIARY:				

## INSTRUCTIONS FOR CERTIFICATION SCHEDULE

Encode all Certification Schedule data in the standard file.

### PART I: COST REPORT AND FACILITY INFORMATION

Login ID – The provider's 13-digit Medical Assistance Provider Number, preceded by the letters "MA", ex. MA0077777777777. This ID may also be found on the "Password and Connectivity" letter mailed to the administrator by the Department.

Test – Allowable responses are "T" (true) or "F" (false). Place a "T" in the space if the provider is submitting the cost report data as a test. Test data is validated but the data is not stored in any database. Data submitted in this manner does not result in a filed cost report. Place an "F" in the space if the provider is filing actual cost report data.

Facility Name – The facility's name at the end of the cost reporting period, as listed on the "Password and Connectivity" letter mailed to the administrator by the Department.

MA No. – The provider's 13-digit Medical Assistance Provider Number, ex. 0077777777777, at the end of the cost reporting period.

Report Period Begin and End Date – The first day and last day of the cost report period.

### PART II: FACILITY AFFILIATION INFORMATION

Chain organizations are generally defined as multiple providers owned, leased, or through any other device, controlled by a single organization. For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, managed, or, through any other device, controlled by one organization. Chain organizations include, but are not limited to, chains operated by for profit/proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations engaged in other activities not directly related to health care.

The controlling organization is known as the chain "home office." Typically, the chain "home office:"

- Maintains uniform procedures in each facility for handling admissions, utilization review, preparation and processing admission notices and bills
- Maintains and centrally controls individual provider cost reports and fiscal records.
- In addition, a major portion of the Medicare audit for each provider in the chain can be performed centrally at the chain "home office."

Line 2a: Enter Yes or No. If "YES", attach a listing of the components of the entire entity.

Line 2b: If Line 2a is yes, enter the name of the entity for Home Office, Management Company and/or Other Controlling Entity.

Line 2c: Enter Yes or No.

### PART III: CONTACT PERSON'S INFORMATION

Contact Person - The person authorized to resolve all concerns regarding the cost report acceptance process or audit.

Contact Person's Name - The contact person's name.

Contact Person's Title - The contact person's title.

Contact Person's Employer - The contact person's employer.

Contact Person's Telephone Number - The contact person's telephone number.

Contact Person's Fax Number - The contact person's fax number.

Contact Person's E-mail Address - The contact person's e-mail address.

#### **PART IV: PREPARER INFORMATION**

Prepared By – Name of the individual who prepared the cost report if the preparer was not an employe of the facility. Otherwise, leave blank.

Preparer's Firm Name – The preparer's firm name.

Firm Telephone Number – The preparer's telephone number.

Firm Fax Number – The preparer's fax number.

Preparer's E-mail Address – The preparer's e-mail address.

#### **PART V: CERTIFICATION STATEMENT**

Each copy of the Certification Report must have an original signature (no photocopies or facsimiles) of an authorized officer or authorized officer or administrator of the facility and an original signature of the preparer (when applicable).

#### **PART VI: MEDICARE INTERMEDIARY**

Name of Medicare Intermediary: - The provider's Medicare Intermediary, if applicable. Otherwise, leave blank.

## SUMMARY

PART I. TYPE OF FACILITY		PART II. TYPE OF ORGANIZATION			
Approved as: <input type="checkbox"/>  (1) General (2) Hospital-Based (3) Special Rehabilitation (4) County		Type of Organization: <input type="checkbox"/>  (1) Voluntary, Non-Profit (2) Proprietary, Individual (3) Proprietary, Partnership (4) Proprietary, Corporation (5) Proprietary, Other (6) Governmental			
PART III. STATISTICAL DATA	LINE NO.	NURSING FACILITY (A)	RESIDENTIAL & OTHER (B)	TOTAL (C)	DATE OF CHANGE (D)
Beds available at beginning of period	(1a)				
Changes in total beds during period	(1ba)				
	(1bb)				
	(1bc)				
	(1bd)				
Beds available at end of period	(1c)				
Beds days available for period	(2)				
Actual resident days for period <i>(SEE INSTRUCTIONS)</i>	(3)				
Percent overall occupancy <i>(Line (3)/Line (2)) (Round to 4 decimals)</i>	(4)				
Percent MA occupancy <i>(Line (6)/Line (3)) (Round to 4 decimals)</i>	(5)				
Total MA resident days of care	(6)				

## INSTRUCTIONS FOR SUMMARY – SCHEDULE A

Encode all Schedule A data in the standard file.

### PART I – II

Place the code number, which describes your facility as of the last day of the reporting period.

### PART III: STATISTICAL DATA

**Line 1:** For the nursing facility and for the residential & other, state the number of beds available for residents at the beginning and the end of the period. Detail for each increase or decrease in the number of beds available must be recorded with the corresponding date of change. Temporary changes because of alteration, repairs, etc., do not affect the bed capacity. Decertified beds should not be included in totals. All certified beds should be included in nursing facility totals, regardless of any restrictions (temporary or otherwise) that may be placed on the MA certified beds or Department of Health (DOH) licensed beds within the specified period of time.

**Line 2:** For the nursing facility and for the residential & other, compute the bed days available for the period. Any increase or decrease in the number of beds during the period must be taken into consideration. Multiply the number of beds by the number of days those beds were available. Where a change in the number of beds occurred, for each change, multiply the number of beds by the actual days those beds were available. Add all such bed days together.

The definition of Available Nursing Facility Bed Days is all days included within the specified period of time during which the beds are MA certified by the Department of Public Welfare (DPW) and licensed by the Department of Health (DOH), regardless of any restrictions (temporary or otherwise) that may be placed on the MA certified beds or the DOH licensed beds within the specified period of time.

**Line 3:** A resident day is the period of service for one resident for one day of care. The day of the resident's admission is counted, but not the day of discharge. When a resident is admitted and discharged on the same day, this period must be counted as one resident day. Hospital reserve bed days shall not be included as days of care. Therapeutic reserve bed days shall be included as days of care.

**Line 4:** The percentage of nursing facility actual resident days to the nursing facility bed days available should be calculated for the nursing facility. Determine the percentage of overall occupancy by dividing the nursing facility actual resident days (Line 3) by the nursing facility bed days available (Line 2). Please be sure the number you encode is expressed in decimal form to the fourth decimal place. (Thus 71.45% is to be encoded in decimal form as .7145).

#### Example:

Actual nursing facility resident days for year		56,000
Nursing bed days available during year		78,375
(200 beds x 150 days plus 225 beds x 215 days)		
Percent occupancy (56,000/78,375)	=	.7145
		(round to
		4 decimals)

**Line 5:** The percentage of MA occupancy should be calculated for the nursing facility. Determine the percent of MA occupancy by dividing the total MA resident days of care (Line 6) by the nursing facility actual resident days (Line 3). Please be sure the number you encode is expressed in decimal form to the fourth decimal place. (Thus 71.45% is to be encoded in decimal form as .7145).

**Line 6:** Record the total actual Medical Assistance (MA) resident days of care. Do not include the hospital reserve bed days. Include therapeutic reserve bed days. If MA pays a Medicare co-insurance per diem amount, the resident day will be charged to Medicare and not to Medical Assistance.

MA Day of Care - A day of care for which the Department pays 100% of the MA rate for an MA resident or  
Day of care for which the Department and the resident pay 100% of the MA rate for the MA resident's care.  
A day of care for which one of the following applies:

- (i) The Department pays 100% of the MA rate for an MA resident.
- (ii) The Department and the resident pay 100% of the MA rate for an MA resident.

- (iii) A Medical Assistance Managed Care Organization (MA MCO) or a Long Term Care Capitated Assistance Program (LTCCAP) provider that provides managed care to MA residents pays 100% of the negotiated rate or fee for an MA resident's care.
- (iv) The resident and either an MA MCO or LTCCAP provider pays 100% of the negotiated rate or fee for an MA resident's care.
- (v) The Department pays for care provided to an MA resident receiving hospice services in a nursing facility.

## SUMMARY OF RESIDENT CENSUS RECORDS

<b>Schedule B</b>
-------------------

DAYS OF CARE												
LINE NO.	MONTH (A)	NURSING FACILITY MA (B)	NURSING FACILITY MA MCO (C)	NURSING FACILITY MA LTCCAP (D)	NURSING FACILITY MA HOSPICE (E)	NURSING FACILITY MEDICARE (F)	NURSING FACILITY ALL OTHER (G)	RESIDENTIAL AND OTHER (H)	TOTAL (I)	LINE NO.	NURSING FACILITY HOSPITAL LEAVE DAYS	
											MA (J)	OTHER (K)
(1)										(1)		
(2)										(2)		
(3)										(3)		
(4)										(4)		
(5)										(5)		
(6)										(6)		
(7)										(7)		
(8)										(8)		
(9)										(9)		
(10)										(10)		
(11)										(11)		
(12)										(12)		
(13)	<b>TOTAL</b>	[1] [4]	[1] [4]	[1] [4]	[1] [4]	[1]	[1]	[2]	[3]	(13)		

- [1] For Line 13: Columns B plus Column C plus Column D plus Column E plus Column F plus Column G must agree to Schedule A, Line 3, Column A.
- [2] Line 13 Column H must agree to Schedule A, Line 3, Column B.
- [3] Line 13 Column I must agree to Schedule A, Line 3, Column C.
- [4] For Line 13: Column B plus Column C plus Column D plus Column E must agree to Schedule A, Line 6, Column A.

## INSTRUCTIONS FOR SUMMARY OF RESIDENT CENSUS RECORDS – SCHEDULE B

Encode all Schedule B data in the standard file.

### COLUMNS

A. MONTH: Months must be encoded as a numerical month, ex. June = "6".

Please Note: A resident day is the period of service for one resident for one day of care. The day of the resident's admission is counted, but not the day of discharge. When a resident is admitted and discharged on the same day, this period must be counted as one resident day. Therapeutic reserve bed days shall be included as days of care. Hospital reserve bed days shall not be included as days of care in Columns B through I.

B. NURSING FACILITY MA: Record by month, the number of MA nursing facility resident days of care. Include only those days for which the Department paid 100% of the MA rate for an MA resident or the Department and the resident combined paid 100% of the MA rate for an MA resident.

C. NURSING FACILITY MA MCO: Record by month, the number of MA MCO nursing facility resident days of care. Include only those days for which a Managed Care Organization (MCO) under contract with the Department paid 100% of the negotiated rate or fee for an MA resident's care or the MCO and the resident combined paid 100% of the negotiated rate or fee for an MA resident's care.

D. NURSING FACILITY MA LTCCAP: Record by month, the number of MA LTCCAP nursing facility resident days of care. Include only those days for which a Long Term Care Capitated (LTCCAP) provider paid 100% of the negotiated rate or fee for an MA resident's care or the LTCCAP provider and the resident combined paid 100% of the negotiated rate or fee for an MA resident's care.

E. NURSING FACILITY MA HOSPICE: Record by month, the number of MA Hospice nursing facility resident days of care for which the Department paid for the care provided to an MA resident receiving hospice services in the nursing facility.

F. NURSING FACILITY MEDICARE: Record by month, the number of Medicare nursing facility resident days of care regardless of type, such as Part A or Medicare Advantage.

G. NURSING FACILITY ALL OTHER: Record by month, the number of All Other nursing facility resident days of care. If a day of care is paid for 100% by any third-party payor other than MA or Medicare, or a combination of MA and any other third-party payor, the day of care should be included in this column.

H. RESIDENTIAL AND OTHER: Record by month, the number of total actual residential and other days provided to match Schedule A, Column B, Line 3.

J. NURSING FACILITY HOSPITAL LEAVE DAYS MA: Do not include in any columns other than J.

K. NURSING FACILITY HOSPITAL LEAVE DAYS OTHER: Do not include in any columns other than K.

**COMPUTATION AND ALLOCATION OF ALLOWABLE COST**

**SCHEDULE C**

(Rounded to Nearest Dollar)

COST CENTERS	LINE NO.	Salary Cost (A)	Fringe Benefits (B)	Other Expenses (C)	Total Expenses (D)	Adjustments (E)	Allowable Cost (F)	ALLOCATION \$		ALLOCATION %		Allocation Basis (K)	LINE NO.
								Nursing Facility (G)	Residential & Other (H)	Nursing Facility (I)	Residential & Other (J)		
<b>I. RESIDENT CARE COSTS</b>													
Nursing	(1)											Direct Salary	(1)
Director of Nursing/RNAC	(2)											Actual Costs	(2)
Related Clerical Staff	(3)											Actual Costs	(3)
Practitioners	(4)											Direct Salary	(4)
Medical Director	(5)											Actual Costs	(5)
Social Services	(6)											%Resident Days	(6)
Resident Activities	(7)											%Resident Days	(7)
Volunteer Services	(8)												(8)
Pharmacy-Prescription Drugs	(9)											Actual Costs	(9)
Over-the-Counter Drugs	(10)											Actual Costs	(10)
Medical Supplies	(11)											Actual Costs	(11)
Laboratory and X-rays	(12)											Actual Costs	(12)
Physical, Occupational & Speech Therapy	(13)											Actual Costs	(13)
Oxygen	(14)											Actual Costs	(14)
Beauty and Barber Services	(15)											Actual Costs	(15)
RC Minor Movable Property	(16)											Sq. Ft. or Actual	(16)
Nurse Aide Training	(17)											Actual Costs	(17)
	(18)											Actual Costs	(18)
	(19)											Actual Costs	(19)
Total Resident Care Costs	(20)												(20)
<b>II. OTHER RESIDENT RELATED COSTS</b>													
Dietary and Food	(21)											# Meals Served	(21)
Laundry and Linens	(22)											Pounds of Laundry	(22)
Housekeeping	(23)											Sq. Ft. or Actual	(23)
Plant Operation & Maintenance	(24)											Sq. Ft. or Actual	(24)
ORR Minor Movable Property	(25)											Sq. Ft. or Actual	(25)
	(26)											Actual Costs	(26)
	(27)											Actual Costs	(27)
Total Other Resident Related Costs	(28)												(28)
<b>III. ADMINISTRATIVE COSTS</b>													
Administrative (Schedule G)	(29)											Total NO Cost	(29)
Total Net Operating (NO) Costs	(30)												(30)
<b>IV. CAPITAL COSTS</b>													
Real Estate Taxes	(31)											Sq. Ft. or Actual	(31)
Major Movable Property	(32)											Sq. Ft. or Actual	(32)
Nursing Facility Assessment/HAI Assessment	(33)												(33)
Depreciation	(34)												(34)
Interest on Capital Indebtedness	(35)												(35)
Rent of Facility	(36)												(36)
Amortization Capital Costs	(37)												(37)
	(38)												(38)
Total Capital Costs	(39)												(39)
Total All Costs	(40)												(40)

## INSTRUCTIONS FOR COMPUTATION AND ALLOCATION OF ALLOWABLE COST – SCHEDULE C

Encode all Schedule C data in the standard file, including cost category descriptions for lines 18, 19, 26, 27 and 38.

### COLUMNS

- A.           **SALARY COST:** Enter the amount of gross salaries and wages of employes of the facility.
- Submit a reconciliation of the wages reported on Schedule C, Column A, Line 40 to the Unemployment Compensation Tax Returns (PA UC-2) or Form 941 tax returns, for each quarter. Tax returns are reported on cash basis (when the employes are paid). The Schedule C wages are reported on the accrual basis (when the wages are earned).
- List the gross wages and pay dates for each payroll register included in the PA UC-2 (or Form 941) tax returns. Include the computations for the beginning and ending accruals reported in the reconciliation.
- Submit a schedule of reconciling items between the MA-11 wages and the PA UC-2 (or Form 941) tax returns. If differences are due to inter-company transfers of employes, submit a schedule showing the employes' names, the dates of transfer, the employes' wage rates at the time of transfer, and the hours worked at each facility. Prepare a schedule of fringe benefits related to inter-company transfer of employes.
- B.           **FRINGE BENEFITS:** Enter such items as the employer's share of FICA, health insurance, life insurance, workers' compensation, employe x-rays, etc. Apportion the fringe benefits to the various expense centers based on the percentage of salaries and wages in each expense center. A more accurate method is acceptable but must be documented.
- C.           **OTHER EXPENSES:** Enter all other general ledger expenses, including contracted services.
- D.           **TOTAL EXPENSES:** Add Columns A, B and C. They must agree with the GAAP General Ledger or other auditable books of record.
- E.           **ADJUSTMENTS:** Enter the adjustments to revenue and expenses brought forward from Schedules D and E respectively. Enter only one net total adjustment for each line. A net increase in expenses must be shown as a positive number. A net decrease in expenses must be shown as a negative number using the negative sign in front of the number.
- F.           **ALLOWABLE COST:** Add Columns D and E.
- G. and H.   **ALLOCATION (\$) TO NURSING FACILITY AND RESIDENTIAL & OTHER:** Allocate Column F costs to Columns G and H based on the Allocation (%) in Columns I and J.
- I. and J.   **ALLOCATION (%) TO NURSING FACILITY AND TO THE RESIDENTIAL & OTHER:** Please be sure the numbers you enter are expressed in decimal form to the fourth decimal place. (Thus 67.75 percent is to be reported in decimal form as .6775 and 50 percent is to be reported as .5000.)
- Where no actual statistics can be feasibly determined, statistics based on time studies gathered for 14 consecutive days every quarter will be accepted.
- J.           **ALLOCATION (%) TO RESIDENTIAL & OTHER:** Submit documentation showing how the reported expenses were allocated, and showing the corresponding percentages. Documentation is adequate if it tracks the expenses from the facility's General Ledger to the cost report. For each allocation calculation, the documentation must include:
- Direct Salary: Trial balance detail showing nursing and residential salary expense allocated. Documentation of the percentage calculation. A condensed salary expense summary may be submitted in place of the trial balance detail.
  - % Resident Days: Schedule of Nursing and Residential & Other resident days and documentation of the percentage calculation.
  - Actual Costs: Trial balance detail showing actual expenses allocated and documentation of the percentage calculation.

- # Meals Served: Schedule documenting actual meals served. The schedule should include headings for the meals served categories on one axis and time (months or weeks), on the other axis with category totals. Resident days times three is not a valid calculation to support the number of meals served. Documentation of the percentage calculation.
- Pounds of Laundry: Schedule documenting pounds of laundry processed monthly. Documentation of the percentage calculation.
- Sq. Ft.: Documentation supporting the facility square feet identifying the individual components of the Nursing and Resident & Other total amounts. Documentation of the percentage calculation including an identification of the areas of Nursing, Residential & Other square feet used to determine the percentage.

K. **ALLOCATION BASIS:** The allocation basis in Column K should be completed for Line 8. The allocation basis for Lines 1-7, 9-19, 21-27, 29, 31 and 32, is preprinted in Column K. Include the preprinted allocation basis in the standard file. For Lines 16, 23-25, and 31-32, note whether square feet or actual is used for the allocation basis. The allocation basis for Line 29 may not be changed.

A facility may use its own more accurate method of allocation if, and only if, the facility has received prior written approval from the Department prior to the cost report year. Prior written approval is not needed to use actual costs. Prior written approval is needed to revert from actual costs to any allocation method other than the preprinted or to change to any other allocation method. All approvals must be sent with the Certification Report each time a cost report is filed. Report any change to the allocation basis in Column K by replacing the pre-printed allocation with the method used.

## LINES

The cost centers on Schedule C are divided as follows:

- I. Resident Care Costs
- II. Other Resident Related Costs
- III. Administrative Costs
- IV. Capital Costs

General ledger expenses will be entered in Columns A, B and C under the appropriate cost center. Send a copy of the combining Detail Trial Balance and any other appropriate supporting documentation used to prepare Schedule C with the Certification Report.

## LINE NO.

### I. RESIDENT CARE COSTS (RC)

1. **NURSING:** Salary and benefit costs and/or contract nursing services to include approved feeding assistants only while providing specific duties related to feeding of residents.
2. **DIRECTOR OF NURSING/REGISTERED NURSE ASSESSMENT COORDINATOR (RNAC):** Salary and benefit costs and/or contract Director of Nursing services or Registered Nurse Assessment Coordinator (RNAC), unless the individual(s) also routinely provides resident care, whereupon the costs should be included with Nursing.
3. **RELATED CLERICAL STAFF:** Salary and benefit costs and/or contract clerical staff services related to the maintenance of resident's medical records.
4. **PRACTITIONERS:** Salary and benefit costs and/or contract practitioners' services including physicians, dentists, and podiatrists. Services on a fee-for-service basis are not allowable costs and should be eliminated in Column E.
5. **MEDICAL DIRECTOR:** Salary and benefit costs and/or contract Medical Director services.
6. **SOCIAL SERVICES:** Salary and benefit costs and/or contract services of social workers and support staff used to provide social services. Do not include costs associated with eligibility determination. (Costs associated with eligibility determination are included on Schedule C, Line 29.)

7. **RESIDENT ACTIVITIES:** Salary and benefit costs and/or contract services for resident activities, including recreational and pastoral services.
8. **VOLUNTEER SERVICES:** Costs necessary for support of volunteers who serve to improve the quality of resident care.
9. **PHARMACY-PRESCRIPTION DRUGS:** The cost for prescription drugs.
10. **OVER THE COUNTER DRUGS:** The cost of non-prescription drugs provided directly to a resident by a facility from its own supply. Examples: laxatives, aspirin, soda bicarbonate, spirits of peppermint, antacid, etc.
11. **MEDICAL SUPPLIES:** Minor medical and surgical supplies routinely provided to residents as part of routine nursing care. For example, cotton, elastic bandages, gauze, syringes, etc.
12. **LABORATORY AND X-RAY:** Salary and benefit costs and/or contract services and related supplies.
13. **PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY:** Salary and benefit costs and/or contract services and therapeutic supplies for physical, occupational and speech therapy.
14. **OXYGEN:** Cost of oxygen and its administration.
15. **BEAUTY AND BARBER SERVICES:** Salary and benefit costs and/or contract services and supplies to provide beauty and barber services. If routine and non-routine beauty and barber expense cannot be identified or are not supplied, beauty and barber revenue (net of any contractual adjustments) will be offset up to the total expense amount. Refer to the Additional Supporting Documents section for more details.
16. **RC MINOR MOVABLE PROPERTY:** Any movable property that has a unit acquisition cost of less than \$500 and is directly related to resident care to include rented/leased items with an imputed purchase price of less than \$500 per unit. Examples of minor movable property include walkers, bed pans, grip balls, buttoners, grippers, and weights.
17. **NURSE AIDE TRAINING:** Cost of state approved Nurse Aide Training and Competency Evaluation Program.
18. **RESIDENT CARE COSTS:** Not to be used for allocation of residential and other costs.
19. **RESIDENT CARE COSTS:** Not to be used for allocation of residential and other costs.
20. **TOTAL RESIDENT CARE COSTS:** Add lines 1 through 19.

## II. OTHER RESIDENT RELATED COSTS (ORR)

21. **DIETARY:** Salary and benefit costs and/or contract services, cost of food, kitchen and dining supplies, cost of preparation, and food service.
22. **LAUNDRY and LINENS:** Salary and benefit costs and/or contract services for laundry, ironing and sewing help, laundry soaps and supplies, outside laundry services, and the purchase or rental of linens. The cost of dry cleaning, mending, or other specialty laundry services for resident personal laundry is nonallowable.
23. **HOUSEKEEPING:** Salary and benefit costs and/or contract services for housekeepers and maids and housecleaning supplies.
24. **PLANT OPERATION AND MAINTENANCE:** Salary and benefit costs and/or contract services for plant operation and maintenance, heat, light, power, repairs, contractual repairs, maintenance, and supplies.
25. **ORR MINOR MOVABLE EQUIPMENT:** Any movable property purchase that has a unit acquisition cost of less than \$500 and is related to Other Resident Related care to include rented/leased items with an imputed price of less than \$500 per unit. Examples include dishes, flatware, cookware, small electric kitchen appliances, bedding and linens, resident care area furnishings such as mattresses, over-the-bed tables, wall hangings and window treatments as well as hand and small electrical tools for maintenance and repair.
26. **OTHER RESIDENT RELATED COSTS:** Not to be used for allocation of residential and other costs.

27. **OTHER RESIDENT RELATED COSTS:** Not to be used for allocation of residential and other costs.

28. **TOTAL OTHER RESIDENT RELATED COSTS:** Add Lines 21 through 27.

### III. ADMINISTRATIVE COSTS

29. **ADMINISTRATIVE:** The detail of general administration is shown on Schedule G. Schedule G total MUST agree with this line.

30. **TOTAL NET OPERATING COSTS:** Add Lines 20, 28, and 29.

### IV. CAPITAL COSTS

31. **REAL ESTATE TAXES:** Property taxes on land and buildings or reasonable payment made in lieu of real estate taxes. Taxes based on gross receipts or revenues are reported at Schedule G. Submit documentation to support an entry of other than blank or zero on Schedule C, line 31. This should include copies of the tax notices which identify the type of tax and taxing authority, the location and description of the property, the tax period and the tax amount. **Proof of payment to the taxing authority must also be submitted in the form of copies of receipted bills, cancelled checks (front and back) or verification from taxing authority on letterhead which includes tax period, location of property, amount paid, date paid and signature.** Reasonable payment made in lieu of real estate taxes must be supported by proof of payment. A copy of the agreement with the taxing authority must also be provided. Submit a schedule reconciling the tax notices to the amount reported on Schedule C, line 31 to include rebates and refunds of real estate taxes and amounts paid and/or unpaid to date.

32. **MAJOR MOVABLE PROPERTY:** Any movable property that has a unit acquisition cost of \$500 or more to include rented/leased items with an imputed purchase price of \$500 or more per unit. Suggested format for documenting major movable property is located at <http://www.pama11.com/downloads/SchCLine32.XLS>.

33. **NURSING FACILITY ASSESSMENT/HEALTH CARE-ASSOCIATED INFECTIONS (HAI) ASSESSMENT:** Nursing facility assessment and health care-associated infections (HAI) assessment payments to include penalties and interest on nursing facility assessments.

34. **DEPRECIATION:** Total depreciation brought forward from Schedule F.

35. **INTEREST ON CAPITAL INDEBTEDNESS:** Interest expense incurred for funds borrowed for capital purposes.

36. **RENT OF FACILITY:** Rent paid to lease the land and buildings used to operate the nursing facility. Facilities that are rented from related parties should ensure that such transactions are fully disclosed on Schedule K.

37. **AMORTIZATION – CAPITAL COSTS:** Include all expense that is capital in nature.

38. **CAPITAL COSTS:** Specify any additional capital cost category.

39. **TOTAL CAPITAL COSTS:** Add Lines 31 through 38.

40. **TOTAL ALL COSTS:** Add Lines 30 and 39.

**REVENUES AND  
ADJUSTMENTS  
TO REVENUES**

**Schedule D**

REVENUES	LINE NO.	MEDICAL ASSISTANCE (A)	MEDICARE PART A (B)	MEDICARE PART B (C)	PRIVATE PAY & OTHER (D)	TOTAL GENERAL LEDGER (E)	NURSING FACILITY (F)	RESIDENTIAL & OTHER (G)	REVENUE ADJUSTMENTS TO SCHEDULE C (H)	SCHEDULE C LINE NUMBER (I)
<b>I. RESIDENT</b>										
Nursing Care	(1)									Line 1
Practitioners	(2)									Line 4
Pharmacy-Prescription Drugs	(3)									Line 9
Over-the-Counter Drugs	(4)									Line 10
Medical Supplies	(5)									Line 11
Laboratory and X-rays	(6)									Line 12
Physical, Occupational & Speech Therapy	(7)									Line 13
Oxygen	(8)									Line 14
Beauty and Barber Services	(9)									Line 15
Exceptional DME Grant Payments	(10)									Attach Schedule
	(11)									
	(12)									
<b>II. OTHER</b>										
Guest and Employe Meals	(13)									Line 21
Discounts	(14)									
Vending Machines	(15)									
Television	(16)									Line 24
Telephone	(17)									Line 29
Unrestricted Interest/Investment Income	(18)									Line 29
Miscellaneous: If any line 19 - 21 greater than \$500, provide separate detail with source & amounts	(19)									
	(20)									
	(21)									
TOTAL: GROSS REVENUES (Add Lines 1 - 21)	(22)									
<b>III. DEDUCTIONS FROM REVENUES</b>										
Uncollectible Accounts	(23)									
Contractual Adjustments	(24)									
	(25)									
Subtotal: Deductions	(26)									
NET REVENUE (Line 22 minus Line 26)	(27)									
LESS: EXPENSES (Sch. C, Line 40, Column D)	(28)									
NET INCOME (LOSS)	(29)									
TOTAL SCHEDULE D ADJUSTMENTS	(30a)									
TOTAL SCHEDULE E ADJUSTMENTS	(30b)									
TOTAL ADJUSTMENTS	(31)									

## INSTRUCTIONS FOR REVENUES AND ADJUSTMENTS TO REVENUES – SCHEDULE D

Encode all Schedule D data in the standard file, including cost category descriptions for lines 11, 12, 20, 21 and 25. The Schedule C line number for Schedule D, Line 10 must be presented on a separate schedule mailed with the Certification Report and is not encoded in the standard file.

**The revenue reported in Column E must be equal to the revenue recorded in the facility's General Ledger, and must include both routine and ancillary revenue from all payor sources. The revenue amounts recorded in Columns A through D must total the amount recorded in Column E. The revenue reported in Column E must be allocated between Column F (Nursing Facility) and Column G (Residential & Other), based upon the gross amount charged to each resident classification. Revenues that are to be offset against Schedule C expenses should be recorded in Column H. An offset may not always be required. However, the revenue/revenue type must be identified. A recommended line for any adjustment to be made on Schedule C is provided in Column I. The revenue offset should be matched with the related expense. If a different Schedule C line is more accurate, insert the actual line used. An offset to Schedule C expenses must be shown as a negative number using a negative sign in front of the number**

### **COLUMN**

**B. MEDICARE PART A:** Medicare Part A revenues regardless of type, including revenues from Medicare Advantage.

### **LINE NO.**

**Line 1 through 12:** Routine daily service revenue should be reported in the appropriate columns as gross revenue by the primary payor source (i.e., if the primary payor is Medicare and the Medical Assistance program pays for co-insurance, the gross routine service revenue should be reported in the appropriate Medicare column). Identify any revenues in Column H that resulted from charges for other than the usual and customary room and board. For example, a facility may buy medical/nursing supplies in bulk, and resell the material. NOTE: If there is an entry in Column E, Line 10 of other than zero, there must also be an entry in Column H, Line 10 of other than zero.

**Line 13 through 17:** The direct and indirect expenses related to these revenue categories are not allowable. The expenses should be eliminated. However, if the revenue is an accurate measure of the direct and indirect expense then the related revenue may be an acceptable offset.

**Line 18:** Line 18, Column D should include all unrestricted interest and investment income. All interest and investment income is unrestricted unless the income is restricted by the donor or the income is specifically excluded by Medical Assistance regulations. Line 18, Column H should offset this income to the amount of administrative interest expense reported on Schedule G, line 12.

**Line 19 through 21:** Identify any other income. If the amount on any of these lines is greater than \$500, separate detail must be attached to the Certification Report, indicating the source, the amount, and where the related Schedule C expenses appear.

**Line 22:** Add Lines 1 through 21.

**Line 23 through 25:** Residents' revenues should be recorded at the established rate even though some charges may not be paid (uncollectible accounts, Line 23) or some payors may pay less than the amount charged (contractual adjustments, Line 24). Lines 23 through 25 must be shown as a positive number if the deduction reduces gross revenue.

**Line 26:** Add Lines 23 through 25.

**Line 27:** Line 22 minus Line 26.

**Line 29:** The net income or net loss must agree with the Comparative Balance Sheet, Schedule L. If it does not, attach a reconciliation with appropriate explanation.

**Line 30:**

- Line 30a is the total Schedule D adjustments.
- Line 30b is the total Schedule E adjustments.

**Line 31:** Add Line 30a and 30b. Line 31, total adjustments MUST agree with Schedule C, Column E, Line 40.

## ADJUSTMENTS TO EXPENSES

EXPENSES	LINE NO.	EXPENSE ADJUSTMENTS TO SCHEDULE C (A)	SCHEDULE C LINE NUMBER (B)
<b>I. NONALLOWABLE COSTS</b>			
Direct Facility Payments	(1)		Attach Schedule
Non-routine Beauty & Barber Expenses	(2)		Line 15
Employee and Guest Meals	(3)		Line 21
Taxes	(4)		Line 29
Free Care or Discounted Services	(5)		
Other Interest	(6)		Line 29
Personal TV	(7)		Line 24
	(8)		
<b>II. EXPENSES NOT NECESSARY TO RESIDENT CARE</b>			
Travel/Entertainment	(9)		Line 29
Dues and Subscriptions	(10)		Line 29
Promotional Advertising	(11)		Line 29
	(12)		
<b>III. EXPENSE ADJUSTMENTS</b>			
Part B Services	(13)		Attach Schedule
Home Office - Adjustment to Cost	(14)		Line 29
Compensation for Services of Sole Proprietors and Partners	(15)		Line 29
Cost of Major Movable Property	(16)		Line 32
Real Estate Taxes	(17)		Line 31
Legal Fees	(18)		Line 29
Excess Administrative Costs (Schedule G)	(19)		Line 29
Related Party Profit (Schedule K, Line 16)	(20)		
	(21)		
<b>IV. NONALLOWABLE COST CENTERS</b>			
Identify:			
Housekeeping	(22)		Line 23
Plant Operation & Maintenance	(23)		Line 24
Administrative Costs	(24)		Line 29
Real Estate Taxes	(25)		Line 31
	(26)		
<b>TOTAL SCHEDULE E ADJUSTMENTS</b>	<b>(27)</b>		

## INSTRUCTIONS FOR ADJUSTMENTS TO EXPENSES – SCHEDULE E

Encode Schedule E data in the standard file, including cost category descriptions for lines 8, 12, 21, and 26. The Schedule C Line Number for Schedule E, lines 1, 13, and 14 must be presented on a separate schedule mailed with the Certification Report and are not encoded in the standard file. All other Column B lines should be encoded in the file.

**Schedule E is a summary of expenses to be adjusted on Schedule C. Complete all applicable items. The expense adjustments will then be entered on Schedule C. An increase in expenses must be shown as a positive number. A decrease in expenses must be shown as a negative number using a negative sign in front of the number. A recommended line for any adjustments to be made on Schedule C is provided in Column B. If a different Schedule C line is more accurate, insert the actual line used. Attach a separate schedule to the Certification Report if more than one Schedule C line item is affected by an adjustment or if additional adjustments are necessary.**

These adjustments are divided into four categories. Many of the adjustments are self-explanatory. For additional information or explanation, refer to 55 Pa Code Chapter 1187 Nursing Facility Services; Case-Mix Reimbursement System regulations.

### I. NONALLOWABLE COSTS

Expenses which are not allowed in entirety or in part.

**Line 1: Costs for prescription drugs, physician services, dental services, dentures, podiatry services, eyeglasses, appliances, x-rays, laboratory services, and any other materials or services covered by payments made directly to nursing facilities.**

**Line 2:** Routine services are defined by each facility and are available to MA residents at no charge. The facility expense for all routine services, regardless of payor type, is allowable. Non-routine services include any additional or supplemental services for which an MA resident can be charged. The expenses for these services are then considered non-routine for all residents in the facility regardless of payor type. The facility expense for all non-routine service is not allowable.

**Line 4:** Nonallowable taxes include Pennsylvania Capital Stock and Franchise Tax, income tax and any taxes based upon net income.

**Line 6:** The regulations at Chapter §1187.56(2) specify several limitations.

### II. EXPENSES NOT NECESSARY TO RESIDENT CARE

Certain expenses are only allowable if related to resident care. For example: reasonable travel for attendance at conventions and meetings for educational purposes is allowable, whereas travel to relocate new personnel is not allowable. Advertising is not allowable unless for new employees or a minimum yellow page listing.

### III. EXPENSE ADJUSTMENTS

Adjustments to increase or decrease the reported cost in Schedule C, Column D.

**Line 13:** To decrease the reported cost by the operating costs incurred in or the income derived from the provision of Medicare Part B coverable services. Regardless of the provider's choice between the Revenue Method or the Cost Method, gross revenues as well as contractual allowances must be broken out on the trial balance according to generally accepted accounting principles.

**Line 14:** To adjust reported Home Office costs.

**Line 15:** To impute customary compensation for a nursing facility position held by an owner/partner.

**Line 16:** To recognize the cost of Major Movable Property acquired or removed from service during the cost reporting period. Include expenditures in excess of the Exceptional DME Grant and attach a detailed schedule.

**Line 18:** To defer until, or recognize at, final adjudication legal fees related to any appeal or action challenging a payment under 55 Pa Code Chapter 1187.

#### **IV. NONALLOWABLE COST CENTERS**

**Adjustment to decrease the reported cost for cost centers which are not related to, or incidental to, resident care or specifically not allowed according to regulations. Such centers include but are not limited to: gift shops, leased space, living quarters, and pharmacies. The costs may also include costs that may apply only part of the time. For example, clerical staff may perform patient billing on behalf of a pharmacist. The portion of clerical time, etc., devoted to the billing process is not allowable and must be eliminated. Direct and indirect expenses of the nonallowable cost centers should be eliminated. The usual indirect cost categories to be applied are presented in IV. NONALLOWABLE COST CENTERS. The nonallowable indirect expenses should be allocated on a reasonable and consistent basis. As a general rule an allocation based upon square footage is acceptable, unless a more accurate method is identified.**

## DEPRECIATION

PROPERTY, PLANT & EQUIPMENT (1)	LINE NO.	Date Acquired (A)	Cost or Other Basis (B)	Accumulated Depreciation To Date (C)	Method of Computing Depreciation (D)	Life or Rate (E)	Depreciation Expense For Period (F)
Land	(1)		\$				
Buildings	(2)			\$			\$
Fixed Equipment	(3)						
Other:	(4)						
Subtotal	(5)						
Movable Property	(6)						
Other Movable (specify)	(7)						
Transportation Equipment	(8)						
	(9)						
	(10)						
<b>TOTAL</b>	(11)		\$	\$ (2)			\$ (3)

(1) Submit a schedule of additions and deletions since the last report period as outlined in Required Supporting Documents for PPE.

(2) Difference between Column B and Column C must equal amount shown on Schedule L, Line 13, Column A.

(3) Line 11, Column F must agree with amount shown on Schedule C, Line 34, Column D.

# INSTRUCTIONS FOR DEPRECIATION – SCHEDULE F

Encode all Schedule F data in the standard file, including line descriptions for lines 4, 9 and 10. An item that has various dates, depreciation methods, or depreciation life's should be reported as "VAR"; straight line depreciation should be reported as "SL".

Property, Plant and Equipment: **The two general categories of property, plant and equipment are fixed and movable.**

**Line 1 – 3:** Fixed property includes: land, buildings and their structural components including detached buildings (garages, etc.), fixed equipment (walk-in refrigerators, heat, ventilation, and air conditioning systems (HVAC)), land improvements (sewage treatment facilities, parking lots, etc.) and building improvements (any item relatively permanent in nature and more or less permanently affixed to the building (sprinkler systems)).

Depreciable costs of construction such as site surveys, architectural and engineering fees, site supervision, inspections, overhead, site preparation, and other capitalized costs are generally allocated among fixed equipment and building costs. Interest charges incurred during construction are generally allocated among all assets purchased with the loan proceeds.

**Line 6:** Movable property includes all other assets such as furniture, fixtures and any other movable items such as wheelchairs, typewriters, copiers, computers, etc. Transportation equipment is reported separately on Line No 8.

**Line 8:** Transportation equipment includes assets that are motor vehicles and are required to be registered by the Department of Transportation. Transportation equipment also includes special motorized conveyances such as golf carts.

**Column A – Date Acquired:** Fill in the year that the asset was acquired. Use "various" (encode as "VAR") if the items were acquired in many different years.

**Column B – Cost or Other Basis:** The cost of the asset as recorded on the general ledger.

**Column C – Accumulated Depreciation to Date:** Enter the total of the accumulated depreciation recorded on the general ledger. Show as a positive number. Do not use negative sign in front of number.

**Column D – Method of Computing Depreciation:** Identify actual methods used to compute the depreciation expense recorded on the general ledger. If different methods are used, enter "various" (encode as "VAR").

**Column E – Life or Rate:** Enter the number of years or the equivalent rate over which the assets are being depreciated. In the case of many different lives in any classification of assets, enter "various" (encode as "VAR").

**Column F – Depreciation Expense For Period:** Enter the amount of the depreciation for the report period as recorded on the general ledger.

## ADMINISTRATIVE COSTS

	LINE NO.	SALARY COST (A)	FRINGE BENEFITS (B)	OTHER EXPENSES (C)	TOTAL EXPENSES (D)
Administrator	(1)				
Office Personnel	(2)				
Management Fees	(3)				
Home Office Costs	(4)				
Professional Services	(5)				
Determination of Eligibility	(6)				
Gift Shop	(7)				
Advertising	(8)				
Travel/Entertainment	(9)				
Telephone	(10)				
Insurance	(11)				
Other Interest	(12)				
Legal Fees	(13)				
Federal/State Corporate/Capital Stock Tax	(14)				
Office Supplies	(15)				
Amortization-Administrative Costs	(16)				
Officer's Life Insurance	(17)				
Admin Minor Movable Property	(18)				
Other: (If greater than \$1,000, provide separate listing)	(19)				
Total Administrative Costs (Schedule C, Line 29)	(20)				
<b>ADMINISTRATIVE ALLOWANCE COMPUTATION</b>					
<b>This computation should be made only after all other Schedule D and Schedule E adjustments.</b>					
Total Net Operating Cost (Schedule C, Column F, Line 30)	(21)	\$			
Administrative Costs (Schedule C, Column F, Line 29)	(22)				
Subtract Line 22 from Line 21	(23)				
Limit on Administrative Costs (Line 23 divided by .88)	(24)				
Excess Administrative Costs (Subtract Line 24 from Line 21. Enter zero if answer is negative. Enter on Schedule E, Line 19.)	(25)	\$			

## INSTRUCTIONS FOR ADMINISTRATIVE COSTS – SCHEDULE G

Encode all Schedule G data in the standard file.

This schedule should identify all administrative costs. The totals on Schedule G, Line 20 should agree with Columns A to D of Schedule C, Line 29.

**Line 1:** Include only salary and benefit costs and/or contract costs for the nursing facility's administrator and assistant administrator.

**Line 2:** Include only salary and benefit costs and/or contract costs for the nursing facility's comptroller, purchasing agent, personnel director, pharmacy consultant, and other persons performing general supervision or management duties. (General office personnel include clerical staff, receptionist, etc.)

**Line 5:** Include salary and benefit cost and/or contract costs for professional services such as accounting and auditing services, consulting services, etc.

**Line 6:** Include only that portion of Social Services staff salary, employer fringe benefits and other expenses that have been incurred in determining the eligibility of residents for Medical Assistance.

**Line 11:** All insurance expense including property, vehicle, and liability insurance except those types of insurance related to mortgages or bonds, and insurance considered as employee fringe benefits such as health and workers compensation.

**Line 12:** Include only non-capital interest expense.

**Line 14:** Include all taxes other than real estate taxes and employer payroll taxes.

**Line 15:** Include all office supplies for all departments.

**Line 16:** Include all expenses that are administrative in nature.

**Line 17:** Include officer's life insurance.

**Line 18:** Any minor movable property that has a unit acquisition cost of less than \$500 and is not related to Resident or Other Resident Related Care to include rented/leased items with an imputed purchased price of less than \$500 per unit.

**Line 19:** Include the balance of expenses not categorized in Lines 1-18. However, if the total is greater than \$1,000, a separate supporting list must be provided with the Certification Report describing the general ledger expense accounts and related amounts. Unspecified costs such as "miscellaneous" shown on the supporting list may not exceed \$1,000 without further clarification.

### ADMINISTRATIVE ALLOWANCE COMPUTATIONS

The maximum allowable cost for administrative costs is 12% of the facility's allowable net operating cost. This allowance computation should be made only after Schedules C, D, and E have been completed.

**Line 21:** Enter the total net operating costs from Schedule C, Column F, Line 30.

**Line 22:** Enter the administrative cost from Schedule C, Column F, Line 29.

**Line 23:** Subtract Line 22 from Line 21.

**Line 24:** Divide the total in Line 23 by 88%, rounded to the nearest whole dollar amount, and enter. This represents the net operating cost including maximum allowable administrative costs.

**Line 25:** Subtract Line 24 from Line 21. If the answer is positive, this is the amount of administrative costs in excess of the 12% limit. This amount should then be entered on Schedule E, Line 19. If the subtraction results in a negative number, there is no administrative disallowance and zero should be entered on Line 25.

**NURSING CARE  
STAFFING  
(Only for Nursing Facility Services)**

<b>EMPLOYEES</b>						
<b>POSITION</b>	<b>LINE NO.</b>	<b>Salary Cost/Fees (A)</b>	<b>Fringe Benefits (B)</b>	<b>Hours Paid (C)</b>	<b>Hours Worked (D)</b>	<b>Number of Full Time Employees or Equivalents at Year End (E)</b>
Registered Nurses	(1)					
Licensed Practical Nurses	(2)					
Nurse Aides	(3)					
Orderlies/Attendants	(4)					
Other (specify)	(5)					
Subtotal	(6)					
<b>REGISTRY/POOLED/CONTRACT STAFF</b>						
Registered Nurses	(7)					
Licensed Practical Nurses	(8)					
Nurse Aides	(9)					
Orderlies/Attendants	(10)					
Other (specify)	(11)					
Subtotal	(12)					
<b>Total Nursing Care</b>	(13)	<b>[1]</b>				

[1] Add Line 6, Column A; Line 6, Column B; and Line 12, Column A

## INSTRUCTIONS FOR NURSING CARE STAFFING – SCHEDULE H

Encode all Schedule H data in the standard file, including line descriptions for lines 5 and 11.

Schedule H is a summary schedule of nursing care staffing for nursing facility services. Do not include any nursing staff information for residential and other areas. Complete all applicable items.

The Total Nursing Care at Line 13, Column A is the sum of Line 6, Columns A and B and Line 12, Column A.

**Column C – Hours Paid:** This column should include all hours paid and reported in the general ledger. This should include applicable vacation, sick leave, and holidays. Do not inflate the “hours paid” for hours reimbursed at a rate in excess of straight time. One hour worked at “time and ½ pay” is equal to one hour worked.

**Column D – Hours Worked:** This column should include all hours personnel actually worked in Direct Resident Care. In-service training, continuing education, nurse aide training, and travel should not be included. Do not inflate the “hours worked” for hours reimbursed at a rate in excess of straight time. One hour worked at “time and ½ pay” is equal to one hour worked.

**Column E – Number of Full Time Employees or Equivalent (FTE) at Year End:** Should be based on a forty-hour work week. Round to the nearest whole number.

**Schedule I**

**SUPPLEMENTAL  
QUESTIONNAIRE**

Code YES as "1"; NO as "0"

LINE NO.		YES	NO	LINE NO.
(1)	Has interest/investment income from sources other than donor restricted or specifically excluded by Medical Assistance Regulations been offset on Schedule D, Line 18?			(1)
(1a)	If "NO", please state amount of income not offset	\$		(1a)
(2)	Have all costs for nonresident meals been deducted from dietary and food expense?			(2)
(2a)	State actual number of meals served:			(2a)
(2b)	Resident days times three is <b>NOT</b> acceptable.			(2b)
(2c)				(2c)
(2d)				(2d)
(2e)				(2e)
(2f)	Provide supporting documentation as prescribed in			(2f)
(2g)	Required Supporting Documentation Section.			(2g)
(3)	Has personal laundry expense for dry cleaning, mending, or other specialty laundry services been deducted from reported laundry expense?			(3)
(3a)	If "NO", state total specialty laundry expense.	\$		(3a)
(4)	Have any capital assets with an acquisition cost of \$500 or more been expensed in net operating costs?  If "YES", attach detail and identify Schedule C line item.			(4)
(5)	Have any administrative expenses been included in any other allowable cost centers (e.g., telephone expense to any other category such as Nursing)?  If "YES", attach a schedule showing cost category, basis of allocation, and amount allocated for each line item.			(5)
(6)	Does the nursing facility share costs or services with another area or entity such as a residential or personal care facility? Identify:  If "YES", shared costs must be allocated per Schedule C instructions.			(6)
(7)	What is the total square footage of the facility?			(7)
(7a)	What is the total square footage of the facility used for nursing facility services?			(7a)
(8)	Do you have any nonallowable cost centers in the facility (such as a gift shop, snack shop, administrator's or other employe's living quarters, and/or other areas not related to resident care)? Identify:			(8)
(8a)	What is the total square footage of the non-allowable cost centers?			(8a)
(9)	Have indirect costs applicable to nonallowable cost centers been eliminated on Schedule E?			(9)

Encode all Schedule I data in the standard file, including the "Identify" designation for lines 2, 6 and 8. Responses of "YES" must be encoded as "1" in the standard file; "NO" must be encoded as "0" (zero).

## SUPPLEMENTAL QUESTIONNAIRE

Code YES as "1"; NO as "0"

LINE NO.		YES	NO	LINE NO.																																				
	List the annual gross salaries/wages and fringe benefits and/or contracted amounts for the report period for the following personnel:																																							
	<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="width: 30%;"></th> <th style="width: 15%;">Salary</th> <th style="width: 15%;">Fringe Benefits</th> <th style="width: 15%;">Contracted</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">Administrator</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Assistant/Associate Administrator</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Chief Dietitian</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Chief of Fiscal Services</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Director of Housekeeping</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Director of Nursing</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">Facility Engineer</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">All Approved Feeding Assistants while providing specific duties</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Salary	Fringe Benefits	Contracted	Administrator				Assistant/Associate Administrator				Chief Dietitian				Chief of Fiscal Services				Director of Housekeeping				Director of Nursing				Facility Engineer				All Approved Feeding Assistants while providing specific duties						
	Salary	Fringe Benefits	Contracted																																					
Administrator																																								
Assistant/Associate Administrator																																								
Chief Dietitian																																								
Chief of Fiscal Services																																								
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Director of Nursing																																								
Facility Engineer																																								
All Approved Feeding Assistants while providing specific duties																																								
(10a)				(10a)																																				
(10b)				(10b)																																				
(10c)				(10c)																																				
(10d)				(10d)																																				
(10e)				(10e)																																				
(10f)				(10f)																																				
(10g)				(10g)																																				
(10h)				(10h)																																				
(11)	Does the facility employ any individuals who are related to the owner(s) or officers/directors?  If "YES", attach a separate schedule identifying Name, Title and/or Function, number of hours worked per week, salaries/wages, fringe benefits, and line of Schedule C on which this is recorded.			(11)																																				
(12)	Have all personal expenses been excluded from the cost report? (Examples: direct or indirect payment for administrator's or owners/employee's living quarters or expenses, personal portion of company car, trips, conventions, meals and lodging, phone, entertainment, etc.)  If "NO", please provide specific details including amounts, Schedule, and line on which this is recorded			(12)																																				
(13)	Were there any loans, notes or advances <u>to</u> officers, employees, members of the Board of Directors, or owners due to the facility during the report period?  If "YES", attach a separate schedule identifying to whom, amount, and interest during report period.			(13)																																				
(14)	Were there any working capital loans, notes, or advances <u>from</u> officers, employees, members of the Board of Directors, or owners due from the facility during the report period?  If "YES", attach a schedule identifying name of lender, purpose of loan, period of loan, interest rate, interest expense and balance of loan at end of report period.			(14)																																				
(15)	Has an adjustment been made for those types of expenses that were disallowed in prior audits or are otherwise nonallowable?			(15)																																				
(16)	Is the facility a Continuing Care Retirement Community (CCRC)?			(16)																																				
(17)	Is it the formal or informal policy of the facility to require an admission fee on or before the date of admission?			(17)																																				

Encode all Schedule I data in the standard file.  
Respond to all questions concerning your facility and cost report information.

**Schedule J**

**STATEMENT OF COMPENSATION**

**OF OWNERS, DIRECTORS, AND RELATED INDIVIDUALS**

Code YES as "1"; NO as "0"

Yes	No
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SCHEDULE J COMPLETED?

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LINE NO.	NAME (A)	Reserved (B)	Title/Function (C)	Business Organization			Time Devoted to Nursing Facility Work		Compensation Included in Allowable Cost		LINE NO.
				Type (D)	% Owned (E)	% P & L (F)	# Hours/Week (G)	% Time/Week (H)	\$ (I)	Schedule C Line # (J)	
(1)											(1)
(2)											(2)
(3)											(3)
(4)											(4)
(5)											(5)
(6)											(6)
(7)											(7)
(8)											(8)
(9)											(9)
(10)											(10)
(11)											(11)
(12)											(12)
(13)											(13)
(14)											(14)
(15)											(15)

## INSTRUCTIONS FOR STATEMENT OF COMPENSATION OF OWNERS, DIRECTORS, AND RELATED INDIVIDUALS - SCHEDULE J

Encode lines 1 through 15 of Schedule J data in the standard file. Include all data for each owner, director, or related individual in the same row as their names appear. Do not skip lines. If more space is needed, include an additional paper schedule with the Certification Report that includes only the additional information not encoded in the standard file.

If Schedule J is not applicable to the provider, code Schedule J Completed? as "NO"; otherwise, code "YES" and complete Schedule J. A response of "YES" must be encoded as "1" in the standard file; "NO" must be encoded as "0" (zero).

If an owner or stockholder or member of the Board of Directors or related individual is compensated directly (salaries, wages, normal fringe benefits, etc.) or indirectly (no salaries and wages but benefits, goods or services, housing, etc.), this information must be included. Also include amount reported on Schedule E, line 15.

A related individual is a person who is associated or affiliated with or has control of or has any ownership or equity in the nursing facility.

**Column A - Name:** Insert the names of all owners, directors, or related individuals who were compensated during the year by the facility.

**Column B – Reserved.**

**Column C - Title/Function:** For each individual listed in Column A, indicate the individual's title and/or function.

**Column D - Type:** Indicate proprietorship, partnership, S corporation, or C corporation. Encode "PR" for proprietorship, "PA" for partnership, "S" for S corporation, or "C" for C corporation.

**Column E - % Owned:** If a sole proprietor, indicate 100%. If a partnership, identify the ownership percentage. If an S corporation or a C corporation, identify the percent of stock owned. Encode up to 4 decimals. Encode 100% as 1.0000; 55% as .5500, etc.

**Column F - % P & L:** If a partnership, indicate the profit and loss participation percentage if it is different than the ownership percentage. Encode up to 4 decimals. Encode 100% as 1.0000; 55% as .5500, etc.

**Column G and H - Hours/Week and % Time/Week:** Indicate both the actual weekly hours devoted to working at the particular facility and the percent of the normal workweek of those hours. Round hours to the nearest whole hour. Encode up to 4 decimals for percent of workweek. Encode 100% as 1.0000; 55% as .5500, etc.

**Column I and J - \$ and Schedule C Line #:** Indicate the amount of direct or indirect compensation (including but not limited to any benefits, bonuses, perquisites, loans, maintenance) included in the allowable costs on Schedule C. Also, indicate the Schedule C line number where the compensation is included.

**Schedule K**

**FACILITY TRANSACTIONS  
WITH RELATED PARTIES**

Code YES as "1"; NO as "0"

Yes	No

SCHEDULE K COMPLETED?

TRANSACTIONS WITH RELATED PARTIES ARE INCLUDED IN:										
LINE NO.	Schedule C Line # (A)	Schedule C Amount (B)	Amount of Profit (C)	Position, Service or Supply (D)	Name of Related Business (E)	EIN (F)	Owner(s) of Related Business (G)	% Ownership in Nursing Facility (H)	% Ownership in Related Business (I)	LINE NO.
(1)	29			Home Office						(1)
(2)										(2)
(3)										(3)
(4)										(4)
(5)										(5)
(6)										(6)
(7)										(7)
(8)										(8)
(9)										(9)
(10)										(10)
(11)										(11)
(12)										(12)
(13)										(13)
(14)										(14)
(15)										(15)
(16)										(16)

Line 15 = Total Column C Profits from any additional Schedule K. Leave blank if no additional lines greater than 14 are needed.

Line 16 = Total Profit for Schedule K in Column C. Must agree with Schedule E, Line 20, Column A.

## INSTRUCTIONS FOR FACILITY TRANSACTIONS WITH RELATED PARTIES - SCHEDULE K

Encode Line 1 as Home Office costs only. All adjustments to Home Office costs shall be reported on Schedule E, line 14.

Encode lines 2 through 14 of Schedule K data in the standard file. Include all data for each row in the same row. Do not skip lines. If more space is needed, include an additional paper schedule with the Certification Report that includes only the additional information not encoded in the standard file.

If Schedule K is not applicable to the provider, code Schedule K Completed? as "NO"; otherwise, code "YES" and complete Schedule K. A response of "YES" must be encoded as "1" in the standard file; "NO" must be encoded as "0" (zero).

This schedule is to summarize all transactions between the facility and related parties. This includes vendors and integrated companies providing multiple services/supplies.

A related party is a person or entity that is associated or affiliated with or has control of or is controlled by the nursing facility or has any ownership or equity interest in the nursing facility. Control as used in this definition means the direct or indirect power to influence or direct the actions or policies of an organization, institution or person.

Report compensation paid by facility to any related individual on Schedule J.

Common ownership, regardless of ownership percentage, as well as the following family relationships are significant father, mother, son, daughter, grandfather, grandmother, grandson, granddaughter, aunt, uncle, nephew, niece, by blood or adoption plus father-in-law, mother-in-law, son-in-law, and daughter-in-law. Examples of related parties would include, but not to be limited to members of the board of directors, nursing home administrators, brother/sister/parent/subsidiary corporations, and partnerships.

**Column A - Schedule C Line #:** Identify the schedule C line number where the related party expenses are reported.

**Column B - Schedule C Amount:** Indicate the amount reported on Schedule C, Column D.

**Column C - Amount of Profit:** Indicate amount of profit in Column C. Losses are reported as zero. A supporting schedule is required to be sent with the Certification Report that shows the calculation used to determine the amount of profit entered in Column C even if the profit is zero. The schedule should also include any additional lines greater than 14 needed to complete the information for the facility. Total profit from Schedule K, line 16, Column C needs to be shown on Schedule E, Line 20, Column A. Examples of supporting schedules can be viewed at <http://www.pama11.com/downloads/schedulek.doc>.

**Column D - Position, Service or Supply:** Describe the position, service or supply provided.

**Column E - Name of Related Business:** Identify the legal names(s) of the related party/business.

**Column F - EIN:** Indicate the federal EIN of the related party/business. Do not encode hyphens.

**Column G - Owner(s) of Related Business:** Identify each owner of the related business who also has ownership in the nursing facility.

**Column H - % Ownership in Nursing Facility:** Identify the ownership percentage in the nursing facility for each owner listed in Column G. Encode up to 4 decimals. Encode 100% as 1.0000; 55% as .5500.

**Column I - % Ownership in Related Business:** Identify the ownership percentage in the related business for each owner listed in Column G. Encode up to 4 decimals. Encode 100% as 1.0000; 55% as .5500.

<b>Schedule L</b>
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## COMPARATIVE BALANCE SHEET

Code YES as "1"; NO as "0"

Yes	No
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SCHEDULE L COMPLETED?		
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	LINE NO.	END OF CURRENT PERIOD (A)	END OF PRIOR PERIOD (B)
<b>CURRENT ASSETS</b>			
Cash on hand and in banks	(1)		
Accounts and notes receivable (Less allowance \$ _____)	(2)		
Inventories (priced at _____)	(3)		
Investments	(4)		
Prepaid expenses	(5)		
Total Current Assets	(6)		
<b>PROPERTY, PLANT AND EQUIPMENT</b>			
Land	(7)		
Buildings	(8)		
Leasehold improvements	(9)		
Equipment	(10)		
Total property, plant and equipment	(11)		
Less accumulated depreciation	(12)		
Net Property, Plant and Equipment	(13)		
<b>OTHER ASSETS</b>			
Notes receivable	(14)		
Other assets	(15)		
TOTAL ASSETS	(16)		
<b>CURRENT LIABILITIES</b>			
Accounts payable	(17)		
Notes payable	(18)		
Accrued salaries, wages, fees payable	(19)		
Deferred income	(20)		
Total Current Liabilities	(21)		
<b>LONG-TERM LIABILITIES</b>			
Mortgage payable	(22)		
Notes payable	(23)		
Other	(24)		
TOTAL LIABILITIES	(25)		
<b>CAPITAL</b>			
Owner's equity (proprietary or partnership)	(26)		
Capital stock outstanding (corporation)	(27)		
Retained earnings (R/E) - beginning of year	(28)		
Current year's operating profit (loss)	(29)		
Other R/E account transactions (net)	(30)		
Balance, end of year	(31)		
Total Capital	(32)		
TOTAL LIABILITIES AND CAPITAL	(33)		

## **INSTRUCTIONS FOR COMPARATIVE BALANCE SHEET – SCHEDULE L**

Encode all Schedule L data in the standard file, including line 2 allowance amount and line 3 method of inventory.

If Schedule L is completed, code Schedule L Completed? as “YES” and complete Schedule L. If Schedule L is not completed, code Schedule L Completed? as “NO” and submit facility-specific certified financial statements with the Certification Report. If consolidated financial statements are submitted they must contain a facility-specific Balance Sheet; if they do not, Schedule L must be completed for the specific nursing facility. A response of “YES” must be encoded as “1” in the standard file; “NO” must be encoded as “0” (zero).

Balance sheet presentation should be in conformity with generally accepted accounting principles.

Schedule L, Line 12 columns A and B. Show as a positive number. Do not use negative sign in front of number.

Schedule L, Line 29 must agree to Schedule D, Line 29. A separate schedule must be attached when there is a number recorded on Schedule L, Line 30.

**PRIVATE PAY AND  
MEDICARE RATE  
CERTIFICATION  
STATEMENTS**

**Schedule MA-58**

<b>PART I. PRIVATE PAY RATE</b>			
LINE NO.	QUESTION	Code YES as "1"; NO as "0"	
(1a)	During the report period, did the Medical Assistance rate charged to the Department exceed the usual and customary charges made to the general public for a room?	YES	NO
(1b)	If YES, give all-inclusive or room and board plus ancillary private pay rate.	\$ .	
<p>If NO, sign and date the following certification statement that will appear on the Certification Report.</p> <p style="margin-left: 40px;">I hereby certify that the facility's usual and customary charges to the general public for a room during this reporting period exceeded the facility's Medical Assistance rate to the Department. I understand that any false claims, statements, or concealment of material fact may be prosecuted under applicable federal or state law. I understand that if I do not sign this statement, the Department will make any necessary gross adjustments to the facility's reimbursement in accordance with 62 P.S. §1406(b).</p>			

<b>PART II. MEDICARE RATE</b>			
LINE NO.	QUESTION	Code YES as "1"; NO as "0"	
(2a)	Indicate the Medicare rate that was in effect during the MA-11 report period (attach schedule).	\$ .	
(2b)	Indicate the effective date of the Medicare rate.		
(2c)	Indicate whether the Medicare rate is an audited rate.	YES	NO
<p>If Medicare Rate (2a) is completed, sign and date the following certification statement that will appear on the Certification Report.</p> <p style="margin-left: 40px;">I hereby certify that the above Medicare per diem rate was/would have been the average Medicare rate as determined by the instructions to Schedule MA-58 for any Medicare resident had that Medicare resident been provided services during the MA-11 report period. I understand that any false claims, statements, or concealment of material fact may be prosecuted under applicable federal or state law.</p>			

<b>PART III. ADMINISTRATOR INFORMATION</b>	
LINE NO.	QUESTION
(3a)	Administrator's Name:
(3b)	Administrator's Telephone Number:
(3c)	Administrator's Fax Number:
(3d)	Administrator's E-mail Address:

**INSTRUCTIONS FOR PRIVATE PAY AND  
MEDICARE RATE CERTIFICATION STATEMENTS SCHEDULE MA-58**

Complete the private pay and Medicare rate information. The Medicare rate for line 2a is calculated as follows:

From the latest Medicare Report that is applicable to the report period	
Medicare Part A Revenues	\$x,xxx,xxx
Less: Related Contractual Adjustments	\$ <u>xxx,xxx</u>
	\$x,xxx,xxx

Divided by: Medicare Part A Days	xx,xxx
Average Medicare Rate (to line 2a, Schedule MA-58) \$	<u>xxx.xx</u>

The effective date of the Medicare Rate will be the end date of the Medicare cost report (line 2b, Schedule MA-58).

## **Supplemental Schedules 1189-A and 1189-B**

**(Applies Only to County Nursing Facilities)**

**County nursing facilities must complete supplemental schedules 1189-A and 1189-B in order to adjust costs to those identified in §1189.51.**

# COMPUTATION AND ALLOCATION OF CHAPTER 1189 ALLOWABLE COSTS

## Schedule 1189-A

(Round to Nearest Dollar)

Complete only if Schedule A, PART I., Approved as = (4) County

COST CENTER	LINE NO.	Ch. 1187 Allowable Costs+Capita (A)	Adjustments from Sch 1189-B (B)	Ch. 1189 Allowable Costs (C)	ALLOCATION \$		ALLOCATION %		Allocation Basis (H)	LINE NO.
					Nursing Facility (D)	Residential & Other (E)	Nursing Facility (F)	Residential & Other (G)		
<b>I. RESIDENT CARE COSTS</b>										
Nursing	(1)								Direct Salary	(1)
Director of Nursing/RNAC	(2)								Actual Costs	(2)
Related Clerical Staff	(3)								Actual Costs	(3)
Practitioners	(4)								Direct Salary	(4)
Medical Director	(5)								Actual Costs	(5)
Social Services	(6)								%Resident Days	(6)
Resident Activities	(7)								%Resident Days	(7)
Volunteer Services	(8)									(8)
Pharmacy-Prescription Drugs	(9)								Actual Costs	(9)
Over-the-Counter Drugs	(10)								Actual Costs	(10)
Medical Supplies	(11)								Actual Costs	(11)
Laboratory and X-rays	(12)								Actual Costs	(12)
Physical, Occupational & Speech Therapy	(13)								Actual Costs	(13)
Oxygen	(14)								Actual Costs	(14)
Beauty and Barber Services	(15)								Actual Costs	(15)
RC Minor Movable Property	(16)								Sq. Ft. or Actual	(16)
Nurse Aide Training	(17)								Actual Costs	(17)
	(18)								Actual Costs	(18)
	(19)								Actual Costs	(19)
Total Resident Care Costs	(20)									(20)
<b>II. OTHER RESIDENT RELATED COSTS</b>										
Dietary and Food	(21)								# Meals Served	(21)
Laundry and Linens	(22)								Pounds of Laundry	(22)
Housekeeping	(23)								Sq. Ft. or Actual	(23)
Plant Operation & Maintenance	(24)								Sq. Ft. or Actual	(24)
ORR Minor Movable Property	(25)								Sq. Ft. or Actual	(25)
	(26)								Actual Costs	(26)
	(27)								Actual Costs	(27)
Total Other Resident Related Costs	(28)									(28)
<b>III. ADMINISTRATIVE COSTS</b>										
Administrative	(29)								Total NO Cost	(29)
Total Net Operating (NO) Costs	(30)									(30)
<b>IV. CAPITAL COSTS</b>										
Real Estate Taxes	(31)								Sq. Ft. or Actual	(31)
Major Movable Property	(32)								Sq. Ft. or Actual	(32)
Nursing Facility Assessment/HAI Assessment	(33)								Actual Costs	(33)
Depreciation	(34)								Sq. Ft. or Actual	(34)
Interest on Capital Indebtedness	(35)								Sq. Ft. or Actual	(35)
Rent of Facility	(36)								Sq. Ft. or Actual	(36)
Amortization Capital Costs	(37)								Sq. Ft. or Actual	(37)
	(38)								Actual Costs	(38)
Total Capital Costs	(39)									(39)
Total All Costs	(40)									(40)
<b>V. CHAPTER 1189 NURSING FACILITY ALLOWABLE COSTS - SUMMARY</b>										
Total Nursing Facility Allowable Costs	(41)									
Total Nursing Facility Resident Days (Sch A, Line 3, Col A)	(42)									
Chapter 1189 Nursing Facility Allowable Costs Per Day	(43)									
MA Days (Sch A, Line 6, Col A)	(44)									
Chapter 1189 MA Nursing Facility Allowable Costs	(45)									

## INSTRUCTIONS FOR CHAPTER 1189 ALLOWABLE COSTS – SCHEDULE 1189-A

Schedule 1189-A must be completed if the type of facility is County, as coded on Schedule A, PART I. Type of Facility; Approved as: County. All other provider types may NOT complete Schedule 1189-A. Schedule 1189-A is used to allocate Chapter 1189 allowable costs between Nursing Facility and Residential & Other and to calculate the MA portion of these costs.

Encode all Schedule 1189-A data in the standard file, including cost category descriptions for lines 18, 19, 26, 27, and 38.

### COLUMNS (Part I, Part II, Part III and Part IV)

**A. CH. 1187 ALLOWABLE COSTS + CAPITAL:** Lines 1 – 32: Column A costs must exactly match the comparable lines in Schedule C, Column F.

Lines 33 – 38: Column A costs must exactly match the comparable lines in Schedule C, Column D.

**B. ADJUSTMENTS FROM SCH 1189-B:** Enter the adjustments brought forward from Schedule 1189-B. Enter only one net total adjustment for each line. A net increase must be shown as a positive number. A net decrease must be shown as a negative number using the negative sign in front of the number.

**C. CH. 1189 ALLOWABLE COSTS:** Add Columns A and B.

**D. and E. ALLOCATION (\$) TO NURSING FACILITY AND RESIDENTIAL & OTHER:** Allocate Column C costs to Column D and E based on the Allocation (%) in Columns F and G.

**F. and G. ALLOCATION (%) TO NURSING FACILITY AND RESIDENTIAL & OTHER:** The allocation percent must be expressed in decimal form to the fourth decimal place. (Thus 67.75 percent is to be reported in decimal form as .6775 and 50 percent is to be reported as .5000.)

The percentage of resident days method for allocating allowable costs to the Nursing Facility and to the Residential & Other is computed by dividing each part's actual resident days as shown on Schedule A by the total actual resident days. (Also shown on Schedule A.)

The percentage of square feet of floor space should be calculated by dividing the amount of floor space specifically utilized by the Nursing Facility and the Residential & Other facility, by the total applicable floor space.

Where no actual statistics can be feasibly determined, statistics based on time studies gathered for 14 consecutive days every quarter will be accepted.

**H. ALLOCATION BASIS:** The allocation basis in Column H should be completed for Line 8. The allocation basis for Lines 1-7, 9-19, 21-27, 29, and 31-38, is preprinted in Column H. Include the preprinted allocation basis in the standard file. For Lines 16, 23-25, 31, 32 and 34-37, note whether square feet or actual is used for the allocation basis. The allocation basis for Lines 29 and 33 may not be changed.

### LINES

The categories on Schedule 1189-A are divided as follows:

- I. Resident Care Costs
- II. Other Resident Related Costs
- III. Administrative Costs
- IV. Capital Costs
- V. Chapter 1189 Nursing Facility Allowable Costs - Summary

**LINE NO.**

**Lines 1 – 40.** See instructions for Schedule C for line item descriptions.

41. **Total Nursing Facility Allowable Costs:** Equal to Line 40, Column D.

42. **Total Nursing Facility Resident Days:** Equal to Schedule A, Line 3, Column A.

43. **Chapter 1189 Nursing Facility Allowable Costs Per Day:** Line 41 divided by Line 42.

44. **MA Days:** Equal to Schedule A, Line 6, Column A.

45. **Chapter 1189 MA Nursing Facility Allowable Costs:** Line 43 times Line 44.

## ADJUSTMENTS TO CHAPTER 1187 ALLOWABLE COSTS

Complete only if Schedule A, PART I., Approved as = (4) County

	LINE NO.	ADJUSTMENTS (A)	SCHEDULE 1189-A LINE NUMBER (B)
<b>I. ADDITIONS ALLOWABLE UNDER CMS Pub 15-1</b>			
Excess Administrative Costs (from Sch. G, Line 25)	(1)		Line 29
Promotional Advertising (Sch. E, Line 11)	(2)		Line 29
Bad Debt Expense	(3)		Line 29
Losses on Sale of Fixed & Movable Assets	(4)		Attach Schedule
	(5)		Attach Schedule
	(6)		Attach Schedule
	(7)		Attach Schedule
Subtotal: Additions Allowable Under CMS Pub 15-1	(8)		
<b>II. ADJUSTMENTS TO CAPITAL AND OTHER COSTS</b>			
Major Movable Property (Sch C, Line 32, Col E)	(9)		Line 32
Nursing Facility Assessment/HAI Assessment (Sch C, Line 33)	(10)		Line 33
Depreciation (Sch C, Line 34)	(11)		Line 34
Exceptional DME	(12)		Attach Schedule
	(13)		Attach Schedule
	(14)		Attach Schedule
	(15)		Attach Schedule
Subtotal: Adjustments to Capital and Other Costs	(16)		
<b>TOTAL ADJUSTMENTS (Line 8 + Line 16)</b>	(17)		

## **INSTRUCTIONS FOR ADJUSTMENT TO 1187 ALLOWABLE COSTS – SCHEDULE 1189-B**

Schedule 1189-B must be completed if the type of facility is County, as coded on Schedule A, PART I. Type of Facility; Approved as: County. All other provider types may NOT complete Schedule 1189-B. Chapter §1189.51 indicates that a cost incurred by a county nursing facility is allowable if the cost is allowable pursuant to CMS Pub. 15-1 or pursuant to Chapter 1187. Schedule 1189-B is intended to capture those costs that should be added to allowable Chapter 1187 costs recorded on Schedule C and to identify allowable capital costs.

Encode all Schedule 1189-B data in the standard file. The Schedule 1189-A Line Number for lines 4 – 7 and 12 – 15 must be presented on a separate schedule mailed with the Certification Report and are not encoded in the standard file. All other Column B lines should be encoded in the file.

**All adjustments to Chapter 1187 allowable costs that are allowable under CMS Pub. 15-1 are to be entered in Schedule 1189-B, Column A. Complete all applicable items. The expense adjustments will then be entered on Schedule 1189-A, Column B. An increase in allowable costs must be shown as a positive number. A decrease must be shown as a negative number using a negative sign in front of the number. A recommended line for any adjustments to be made on Schedule 1189-A is provided in Column B of Schedule 1189-B. If a different Schedule 1189-A line is more accurate, insert the actual line used. Attach a separate schedule to the Certification Report if more than one Schedule 1189-A line item is affected by an adjustment or if additional adjustments are necessary.**

**Line 1:** CMS Pub. 15-1 does not limit administrative costs. Add back any excess administrative cost from Schedule G, Line 25.

**Line 2:** Reasonable costs of yellow page advertising is allowable under CMS Pub. 15-1. Add back any promotional advertising of this nature recorded on Schedule E, Line 11.

**Line 3:** Bad debt expense related to deductible and coinsurance amounts are allowable under CMS Pub. 15-1. Add back any bad debt expense deducted from Chapter 1187 total costs.

**Line 4:** Certain losses on the sale of fixed and movable assets are allowed under CMS Pub. 15-1. Consult this publication to determine if expenses deducted from Chapter 1187 total costs may be added back on Line 4.

**Lines 5 – 7:** Record any other amounts to add back expenses that were deducted from Chapter 1187 total costs but are allowable under CMS Pub. 15-1.

**Line 9:** The cost of Major Movable Property recorded on Schedule C, Line 32, that is also accounted for on Schedule C, Line 34. Depreciation should be deducted on Line 9 since depreciation is an allowable Chapter 1189 cost.

**Line 10:** Nursing facility assessment and health care-associated infections (HAI) assessment payments recorded on Schedule C, Line 33 should be adjusted, if necessary, to total the assessment fees for the nursing facility assessment quarters covering the cost reporting period and HAI assessment paid during the cost reporting period. These fees are an allowable Chapter 1189 cost.

**Line 11:** Depreciation recorded on Schedule C, Line 34 should be adjusted, if necessary, since depreciation is an allowable Chapter 1189 cost.

**Line 12:** Any amount recorded on Schedule D to offset an Exceptional DME grant payment should be added back since the necessary, reasonable and prudent costs of the exceptional DME and the related services and items identified in the nursing facility's grant are allowable costs.

**Lines 13 - 15:** Record any other amounts to adjust Chapter 1187 expenses that were deducted from Chapter 1187 total costs but are allowable under CMS Pub. 15-1.

**Line 17: Add lines 8 and 16. Line 17, total adjustments, MUST agree with Schedule 1189-A, Column B, Line 4.**