SCHEDULE NF-1
PROVIDER INFORMATION

DER NAME: _____ _____

PROVIDER NUMBER: _____

period from _____ to _____

Leap Year ☐ 366 365 ☐

Street Address: _____
P.O. Box: _____
City: _____
State: _____
Zip Code: _____

Phone: ( ) _____
Fax: ( ) _____

on by Officer of Facility
Y CERTIFY that I have examined the accompanying Kentucky
Cost Report for the period ended 01/01/2000
to the best of my knowledge and belief, they are true and
atements prepared from the books and records of 0
ance with applicable program directives, except as noted.

(Print) _____
Officer or Administrator of Facility

(Signed) _____
Officer or Administrator of Facility

_____
Title

SCHEDULE NF-2
WAGE AND SALARY INFORMATION

PROVIDER NAME:
PROVIDER NUMBER:

FYE: 01/01/2000

Pay period start date: _____ End date: _____

A. Wage Information

Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	$0
B. LPN	0	0	$0
C. Aides	0	0	$0
D. Director of Nursing	0	0	$0
E. Activities	0	0	$0
F. Medical Records	0	0	$0
G. Dietary	0	0	$0
H. Housekeeping/Laundry	0	0	$0
I. Social Services	0	0	$0
J. Maintenance	0	0	$0
Total	0	0	$0

B. Contracted Services

Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	$0
B. LPN	0	0	$0
C. Aides	0	0	$0
Total	0	0	$0

C. Benefits Paid for by Nursing Facility

	Totals taken from FYE 01/01/2000
Health Insurance	$0
Life Insurance	$0
Retirement	$0
Workers Compensation	$0
F	$0
Total	$0

SCHEDULE NF-3
STAFF INFORMATION

PROVIDER NAME:
PROVIDER NUMBER:

FYE: 01/01/2000

	Number of Patient Days						
	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
Patient Census	0	0	0	0	0	0	0
	Number of Staff on Payroll						
Staff Category	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
RN							
RN Staffing - Day	0	0	0	0	0	0	0
RN Staffing - Evening	0	0	0	0	0	0	0
RN Staffing - Overnight	0	0	0	0	0	0	0
LPN							
LPN Staffing - Day	0	0	0	0	0	0	0
LPN Staffing - Evening	0	0	0	0	0	0	0
LPN Staffing - Overnight	0	0	0	0	0	0	0
Aides							
Aide Staffing - Day	0	0	0	0	0	0	0
Aide Staffing - Evening	0	0	0	0	0	0	0
Aide Staffing - Overnight	0	0	0	0	0	0	0
Food Service							
Food Service Workers- Day	0	0	0	0	0	0	0
Food Service Workkers - Evening	0	0	0	0	0	0	0
Support Personnel							
Housekeeping/Laundry Service Workers	0	0	0	0	0	0	0
Social Services Worker	0	0	0	0	0	0	0
Activities Worker	0	0	0	0	0	0	0
Medical Records Worker	0	0	0	0	0	0	0
Maintenance Worker	0	0	0	0	0	0	0
Director of Nursing	0	0	0	0	0	0	0

SCHEDULE NF-7
ALLOCATION STATISTICS

PROVIDER NAME:
OVIDER NUMBER:

FYE: 01/01/2000

NCILLARY CHARGES	(1) TOTAL	(2) MEDICAID	(3) MEDICAID %
HYSICAL THERAPY	$0	$0	0.0000%
RAY	$0	$0	0.0000%
ABORATORY	$0	$0	0.0000%
XYGEN/RESP. THERAPY	$0	$0	0.0000%
PEECH	$0	$0	0.0000%
OCUPATIONAL THERAPY	$0	$0	0.0000%
OTAL	$0	$0	

OCUPANCY STATISTICS	(1) CERTIFIED NURSING FACILITY	(2) NON-CERTIFIED NURSING FACILITY	(3) OTHER LONG-TERM CARE
ED BEDS AT GINNING OF PERIOD	0	0	0
CENSED BEDS AT ND OF PERIOD	0	0	0
D DAYS AVAILABLE	0	0	0
TAL PATIENT DAYS	0	0	0
OCCUPANCY	0	0	0
MAP PATIENT DAYS	0		
KMAP OCCUPANCY	0		

ED DAYS AVAILABLE - CERTIFIED NURSING FACILITY ONLY

gining Date	Ending Date	Days		Beds		Bed Days Available
01/01/2000		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
		0	x	0	=	0
	TOTAL DAYS	0		TOTAL BED DAYS AVAILABLE		0

SCHEDULE NF-8
MISCELLANEOUS INFORMATION

PROVIDER NAME:
ROVIDER NUMBER:

FYE: 01/01/2000

Current Ownership

t the current owners and the percent owned. If the facility is corporately owned, the officers of the company and their respective title.

Name	Percent Owned

e facility had a change of ownership in the past fiscal year?
ge of ownership is defined as the transfer of the assets of a ry. The sale of stock in a facility does not constitute a change wnership.

Yes ☐ No ☐

s, indicate the new owners and the percent owned. If the facility is corporately owned, he officers of the company and their respective title.

Name	Percent Owned