COMMONWEALTH OF KENTUCKY

Cabinet for Health Services

Department for Medicaid Services

COST-BASED FACILITY

COST REPORT

Edition 4/00

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____ Status
to _____ Leap Year ☐ 365 ☐

A. Type of Control

1. Voluntary Non-Profit
   - Church ☐
   - Other(Specify) ☐
   - _____
   - _____
2. Proprietary
   - Individual ☐
   - Partnership ☐
   - Corporation ☐
   - Other(Specify ☐
   - _____
   - _____
3. Government
   - ☐ State _____
   - ☐ County _____
   - ☐ City _____
   - ☐ Other(Specify)
   - _____
   - _____

B. Statement of costs of services from Related Organizations

1. In the amount of costs to be reimbursed by the MEDICAID Program, are any costs included which are the result of transactions with a related organization?

   Yes ☐ No ☐ (If "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Costs incurred as the result of transactions with related organizations.

Schedule	Line #.	Item	Amount

D. Name & percent of direct or indirect ownership of the related organization.

Name of Owner	Name of Related Organization	Percent

E. Statement of Compensation of Owners

Name	Title & Function	Percent of Customary Work Week Devoted to Business	Partners % of Operating Profit or Loss	Corp. Off. % of Vendor's Stock Owned	Total Compensation

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For The Period from _____
to _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

Name	Title	Percent of Customary Work Week Devoted to Business	Percent of Period Employed	Total Compensation for the Period

G. Has the facility had a change of ownership in the past fiscal year?
A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes ☐ No ☐

If yes, indicate the new owners and the percent owned. (If corporate owned, list individuals.)

Name	Percent Owned

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended
and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of
in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator of Facility

_____
Title

ANNUAL COST REPORT
SCHEDULE B
STATEMENT OF INCOME AND EXPENSES

VENDOR NAME: ENDOR NUMBER FYE

1. Total Patient Revenues		
2. Less: Allowances and discounts on patients' accounts		
3. Net Patient Revenues		$ -
4. Less: Total operating expenses		
5. Net income from services to patients		$ -
OTHER INCOME		
6a. Unrestricted contributions, donations, bequests, etc.		
6b. Restricted contributions, donations, bequests, etc.		
7a. Income from unrestricted investments		
7b. Income from restricted investments		
8. Vending machine commission		
9. Revenue from meals sold to employees and guests		
10. Revenue from sale of drugs, supplies, etc., sold to non-patients		
11. Revenue from telephone and telegraph service		
12. Revenue from rental of non-patient facilities		
13. Revenue from Beauty/Barber Shop		
14. Purchase discounts		
15. Other (specify)		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		
24.		
25.		
26.		
27.		
28.		
29.		
30.		
31. Total other income		-
32. Total of line 5 and line 31		-
OTHER EXPENSES (Specify)		
33.		
34.		
35.		
36.		
37.		
38.		
39.		
40.		
41.		
42.		
43.		
44.		
45.		
46.		
47.		
48.		
49. Total other expenses		
50. NET INCOME FOR THE PERIOD (line 32 less line 49)		

ANNUAL COST REPORT
SCHEDULE C
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

ASSETS

		(1) Per Books	(2) Adjustments	(3) Balance
	Current Assets			
1.	Cash			$ -
2.	Notes and Accounts Receivable			$ -
3.	Other Receivables			$ -
4.	Less: Allowance for Uncollectable Accounts			$ -
5.	Inventory			$ -
6.	Prepaid Expenses			$ -
7.	Investments			$ -
8.	Other (Specify)			$ -
				$ -
				$ -
				$ -
9.	*Total Current Assets*	$ -	$ -	$ -
	Fixed Assets			
10.	Land			$ -
11.	Building and Leasehold Improvements			$ -
12.	Less: Accumulated Depreciation			$ -
13.	Fixed Equipment			$ -
14.	Less: Accumulated Depreciation			$ -
15.	Major Movable Equipment			$ -
16.	Less: Accumulated Depreciation			$ -
17.	Motor Vehicles			$ -
18.	Less: Accumulated Depreciation			$ -
19.	Minor Equipment			$ -
20.	Less: Accumulated Depreciation			$ -
21.	*Total Fixed Assets*	$ -	$ -	$ -
	Other Assets			
22.	Investments			$ -
23.	Lease Deposits			$ -
24.	Due from Owners or Officers (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
				$ -
25.	Other (Specify)			$ -
				$ -
				$ -
				$ -
				$ -
26.	*Total Other Assets*	$ -	$ -	$ -
27.	Total Assets	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C (cont.)
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

LIABILITIES

	Current Liabilities	(1) Per Books	(2) Adjustments	(3) Balance
28.	Accounts Payable			$ -
29.	Notes Payable			
30.	Current Portion of Long Term Debt			
31.	Salaries and Fees Payable			
32.	Payroll Taxes Payable			
33.	Income Taxes Payable			
34.	Deferred Income Payable			
35.	Other (Specify)			
36.	*Total Current Liabilities*	$ -	$ -	$ -
	Long Term Liabilities			
37.	Mortgage Payable			$ -
38.	Notes Payable			
39.	*Total Long Term Liabilities*	$ -		$ -
40.	Total Liabilities	$ -	$ -	$ -

CAPITAL AND OWNERS' EQUITY

41.	Common Stock			$ -
42.	Preferred Stock			
43.	Treasury Stock			
44.	Retained Earnings			
45.	Other (Specify)			
46.	Total Capital and Owners' Equity	$ -	$ -	$ -
47.	Total Liabilities and Capital	$ -	$ -	$ -

ANNUAL COST REPORT
SCHEDULE C-1
BALANCE SHEET AND EQUITY CAPITAL ADJUSTMENTS

VENDOR NAME: **VENDOR NUMBER:** **FYE**

ITE	EXPLANATION	AMOUNT	CLASSIFICATION ADJUSTED ACCOUNT	LINE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
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47				
48				
49				
50				
51				
52				
53				
54				
55				
56	TOTAL	$ -		

ANNUAL COST REPORT -- SCHEDULE D-1 -- NURSING SERVICES COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloc. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloc. of Costs
1	Director of Nursing Salary							
2	R.N. Salaries							
3	L.P.N. Salaries							
4	C.M.A. Salaries							
5	Aides Salaries							
6	Other Salaries_							
7	Other Salaries_							
8	Other Salaries_							
9	*Subtotal-Salaries*							
10	Employee Benefits Reclassification							
11	Nursing Contracted Services							
12	Medical Records Salaries							
13	Medical Director Fees							
14	Pharmacy Consultant Fees							
15	Physician Services							
16	Nursing Education & Training							
17	Nursing Travel Expense							
18	Medical Supplies							
19	Adult Diapers & Underpads							
20	Nursing Equipment Rental							
21	Nursing Small Equip. Purchases							
22	Other Expense_							
23	Other Expense_							
24	Other Expense_							
25	Other Expense_							
26	Other Expense_							
27	Other Expense_							
28	Other Expense_							
29	Other Expense_							
30	Other Expense_							
31	Other Expense_							
32	Other Expense_							
33	Other Expense_							
34	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-2 -- OTHER CARE RELATED COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1) Care Related	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs
1	Activities Salaries							
2	Social Services Salaries							
3	Other Salaries_							
4	Other Salaries_							
5	Other Salaries_							
6	*Subtotal-Salaries*							
7	Employee Benefits Reclassification							
8	Activities Supplies							
9	Social Services Supplies							
10	Training & Education Expense							
11	Travel Expense							
12	Other Expense_							
13	Other Expense_							
14	Other Expense_							
15	Other Expense_							
16	Other Expense_							
17	Other Expense_							
18	Other Expense_							
19	Other Expense_							
20	Other Expense_							
21	Other Expense_							
22	Other Expense_							
23	Other Expense_							
24	Other Expense_							
25	Other Expense_							
26	Other Expense_							
27	Other Expense_							
28	Other Expense_							
29	Other Expense_							
30	Other Expense_							
31	Raw Food							
32	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

PAGE 1

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
	Dietary								
1	Dietary Salaries								
2	Other Salaries_								
3	Other Salaries_								
4	Other Salaries_								
5	*Subtotal-Salaries*								
6	Employee Benefits Reclassification								
7	Dietary Consultant Fees								
8	Dietary Supplies								
9	Equipment Rental								
10	Small Equipment Purchases								
11	Other Dietary Expense_								
12	Other Dietary Expense_								
13	Other Dietary Expense_								
14	Other Dietary Expense_								
15	Other Dietary Expense_								
16	Other Dietary Expense_								
17	Other Dietary Expense_								
18	Other Dietary Expense_								
19	Other Dietary Expense_								
20	*Total Dietary Expense*								
	Housekeeping & Plant Operation								
21	Housekeeping Salaries								
22	Plant Oper. & Maint. Salaries								
23	Other Salaries_								
24	Other Salaries_								
25	Other Salaries_								
26	*Subtotal-Salaries*								
27	Employee Benefits Reclassification								
28	Housekeeping Supplies								
29	Plant Oper. & Maint. Supplies								
30	Equipment Rental								
31	Repairs & Maintenance-Building								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

PAGE 2

VENDOR NAME: VENDOR NUMBER: FYE

Edition 4/00

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
32	Repairs & Maintenance-Equipment								
33	Repairs & Maintenance-Grounds								
34	Small Equipment Purchases								
35	Gas								
36	Electricity								
37	Water & Sewage								
38	Garbage Pick-up								
39	Contracted Services								
40	Pest Control Services								
41	Property Taxes								
42	Insurance-Property, Plant & Equip.								
43	Other Hskg. & Plant Op._								
44	Other Hskg. & Plant Op._								
45	Other Hskg. & Plant Op._								
46	Other Hskg. & Plant Op._								
47	Other Hskg. & Plant Op._								
48	Other Hskg. & Plant Op._								
49	Other Hskg. & Plant Op._								
50	Other Hskg. & Plant Op._								
51	Other Hskg. & Plant Op._								
52	Other Hskg. & Plant Op._								
53	Other Hskg. & Plant Op._								
54	Other Hskg. & Plant Op._								
55	Other Hskg. & Plant Op._								
56	*Total Housekeeping & Plant Oper.*								
	Laundry								
57	Laundry Salaries								
58	Other Salaries_								
59	Other Salaries_								
60	Other Salaries_								
61	*Subtotal-Salaries*								
62	Employee Benefits Reclassification								
63	Laundry Supplies								
64	Linens & Bedding								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Allocn. of Costs	(8) Non-Certified & Non-Nursing Fac. Allocn. of Costs	(9) Ancillary Hospital-Based Facility Only
65	Laundry Contracted Services								
66	Other Laundry Expense_								
67	Other Laundry Expense_								
68	Other Laundry Expense_								
69	Other Laundry Expense_								
70	Other Laundry Expense_								
71	Other Laundry Expense_								
72	Other Laundry Expense_								
73	Other Laundry Expense_								
74	Other Laundry Expense_								
75	*Total Laundry Expense*								
	Administrative & General								
76	Salaries-Officers								
77	Salaries-Administrator								
78	Salaries-Office Staff								
79	Other Salaries_								
80	Other Salaries_								
81	Other Salaries_								
82	*Subtotal-Salaries*								
83	Management Fees								
84	Home Office Costs								
85	Board of Directors Fees								
86	FICA								
87	Workmen's Compensation								
88	Unemployment Insurance								
89	Medical Insurance								
90	Life Insurance								
91	Telephone								
92	Dues & Subscriptions								
93	Office Supplies								
94	Equipment Rental								
95	Printing & Postage								
96	Legal Fees								
97	Accounting Fees								

ANNUAL COST REPORT -- SCHEDULE D-3 -- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
98	Contracted Services								
99	Utilization Review								
100	Travel & Seminars								
101	Advertising-Help Wanted								
102	Advertising-Other								
103	Small Equipment Purchases								
104	Licenses & Fees								
105	Interest Expense-Non-Capital								
106	Other Expense_								
107	Other Expense_								
108	Other Expense_								
109	Other Expense_								
110	Other Expense_								
111	Other Expense_								
112	Other Expense_								
113	Other Expense_								
114	Other Expense_								
115	Other Expense_								
116	Other Expense_								
117	Other Expense_								
118	Other Expense_								
119	Other Expense_								
120	Other Expense_								
121	Other Expense_								
122	Other Expense_								
123	Other Expense_								
124	Other Expense_								
125	Other Expense_								
126	Other Expense_								
127	Other Expense_								
128	Other Expense_								
129	Other Expense_								
130	HEALTH CARE PROVIDER TAX								
131	*Total Admin. & General Exp.*								

ANNUAL COST REPORT -- SCHEDULE D-4 -- CAPITAL COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Cost or Alloc.	(7) Certified Nursing Facility Alloca. of Costs	(8) Non-Certified & Non-Nursing Fac. Alloca. of Costs	(9) Ancillary Hospital-Based Facility Only
1	Depreciation-Building								
2	Depreciation-Equipment								
3	Interest Expense-Capital Related								
4	Rent								
5	Land Improvements								
6	Leasehold Improvements								
7	Amortization of Start-up Costs								
8	Other Capital Costs_								
9	Other Capital Costs_								
10	Other Capital Costs_								
11	Other Capital Costs_								
12	Other Capital Costs_								
13	Other Capital Costs_								
14	Other Capital Costs_								
15	Other Capital Costs_								
16	Other Capital Costs_								
17	Other Capital Costs_								
18	Other Capital Costs_								
19	Other Capital Costs_								
20	Other Capital Costs_								
21	Other Capital Costs_								
22	Other Capital Costs_								
23	*Total*								

Grand Totals

		(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
24	Totals of Schedules D-1 through D-4								
25	Total of Schedule D-5, Column 8								
26	Total Routine CNF Cost								
27	Totals from Schedule D-5								
28	Total Cost								

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

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	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Physical Therapy							
1	Physical Therapist Salaries							
2	Physical Therapist Asstnts. Salaries							
3	Physical Therapist Aides Salaries							
4	Other Salaries_							
5	*Subtotal-Salaries*							
6	Employee Benefits Reclassification							
7	Contracted Services							
8	Equipment Depreciation							
9	Other Expenses_							
10	Other Expenses_							
11	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col. 4)						
12	*Total*							
	X-Ray							
13	Professional Salaries							
14	Other Salaries_							
15	*Subtotal-Salaries*							
16	Employee Benefits Reclassification							
17	Supplies							
18	Equipment Depreciation							
19	Other Expenses_							
20	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)						
21	*Total*							
	Laboratory							
22	Professional Salaries							
23	Other Salaries_							
24	*Subtotal-Salaries*							
25	Employee Benefits Reclassification							
26	Supplies							
27	Equipment Depreciation							
28	Other Expenses_							
29	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)						
30	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Oxygen/Respiratory Therapy							
31	Respiratory Therapist Salaries							
32	Respiratory Therapist Assistant Sal							
33	Respiratory Therapist Aides Salaries							
34	Other Salaries_							
35	*Subtotal-Salaries*							
36	Employee Benefits Reclassification							
37	Supplies							
38	Equipment Depreciation							
39	Other Expenses_							
40	Other Expenses_							
41	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col. 4)						
42	*Total*							
	Speech							
43	Professional Salaries							
44	Other Salaries_							
45	*Subtotal-Salaries*							
46	Employee Benefits Reclassification							
47	Equipment Depreciation							
48	Other Expenses_							
49	Other Expenses_							
50	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4)						
51	*Total*							
	Other							
52	Professional Salaries							
53	Other Salaries_							
54	*Subtotal-Salaries*							
55	Employee Benefits Reclassification							
56	Equipment Depreciation							
57	Other Expenses_							
58	Other Expenses_							
59	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4)						
60	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Drugs							
61	Pharmicist Salaries							
62	Other Salaries_							
63	*Subtotal-Salaries*							
64	Employee Benefits Reclassification							
65	Drugs							
66	Equipment Depreciation							
67	Other Expenses_							
68	Other Expenses_							
69	Other Expenses_							
70	Other Expenses_							
71	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9, X Sch. F, Section B, Line 9, Col. 4)						
72	*Total*							

SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected (Schedule & Line # Affected) (e.g. D3-1)
1				
2				
3				
4				
5				
6				
7				
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9				
10				
11				
12				
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15				
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47				
48				
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54				
55				
56				
57				
58				
59				
60				
61	*Total*			

SCHEDULE D-7
ADJUSTMENTS TO EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) * Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch. & Line # Affected (e.g. D3-1)
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts & Income Designated by the donor for a specific purpose			
5	Beauty & Barber Shop **			
6	Excess Owners Compensation			
7	Telephone Serv.(Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of Drugs to other than Patients			
11	Sale of Medical & Surgical Supplies to other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Emp. & Others			
15	Rental of Facility Space			
16	Trade, Qty, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss on Disposition of Assets			
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
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42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53	*Total*			

* (A) COST (B) REVENUE

** *Beauty & Barber Shop Revenues in excess of Beauty & Barber Shop supply & personnel cost is to be adjusted in an Administrative & General cost center.*

ANNUAL COST REPORT -- SCHEDULE E -- ANCILLARY SETTLEMENT

VENDOR NAME: VENDOR NUMBER: FYE

(1)	(2) Direct (From Sch. D-5, Col.6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable To KMAP)
1 Physical Therapy				
2 X-Ray				
3 Laboratory				
4 Oxygen/Respiratory Therapy				
5 Speech				
6 Other				
7 Drugs				
8 *Total*				

Medicaid Services use only.
TENTATIVE ANCILLARY ☐
ANCILLARY SETTLEMNT ☐

ANNUAL COST REPORT

SCHEDULE F

ALLOCATION STATISTICS

VENDOR NAME: FYB FYE

Status VENDOR NUMBER: DAYS MONTHS

A. NURSING SALARIES

Leap Year ☐ 365 ☐

1. CERTIFIED NURSING FACILITY _____
2. OTHER _____
3. CERT. NURSING FAC. PERCENTAGE _____

ALLOCATION METHOD:

PATIENT DAYS ☐ VALID TIME STUDY ☐

DIRECT COST ☐ DIRECT HOURS ☐

OTHER APPROVED METHOD ☐

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1. CERT. NURSING FACILITY				
2. OTHER				
3. PHYSICAL THERAPY *				
4. X-RAY *				
5. LABORATORY *				
6. OXYGEN/RESP. THERAPY *				
7. SPEECH *				
8. OTHER *				
9. DRUGS *				
10. TOTAL				

* For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	(1) MEALS	(2) PERCENT
1. CERT. NURSING FACILITY		
2. ALL OTHER		
3. TOTAL		

ALLOCATION METHOD:

MEAL COUNT: ☐ 3 * INPATIENT DAYS: ☐

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1. PHYSICAL THERAPY					
2. X-RAY					
3. LABORATORY					
4. OXYGEN/RESP. THERAPY					
5. SPEECH					
6. OTHER					
7. DRUGS					
8. TOTAL					

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1. LICENSED BEDS AT BEGINNING OF PERIOD			
2. LICENSED BEDS AT END OF PERIOD			
3. BED DAYS AVAILABLE			
4. TOTAL PATIENT DAYS			
5. % OCCUPANCY			
6. KMAP PATIENT DAYS			
7. % KMAP OCCUPANCY			

F. ADDITIONAL STATISTICS

1. DIRECT ROUTINE NURSING HOURS - CERTIFIED NURSING FACILITY ONLY	
2. TOTAL DIRECT DIETARY HOURS	
3. TOTAL DIRECT HOUSEKEEPING HOURS	

Edition 4/00

KMAP-2

SUPPLEMENTAL MEDICAID SCHEDULE

COMPUTATION OF DUAL LICENSED ANCILLARY COST

VENDOR NAME: _____ VENDOR NUMBER: _____ FYB _____ FYE _____ DAYS

Leap Year ☐ 365 ☐

ANCILLARY COST CENTERS	TOTAL ANC. COST COL. 1	TOTAL DIRECT COST COL. 2	DIRECT COST % COL.3 (2/1)	TOTAL INDIR. COST COL. 4	INDIR. COST % COL. 5 (4/1)	RATIO OF COST TO CHG COL.6	DIRECT COST TO CHG RATIO COL. 7 (6X3)	MEDICAID DUAL INPATIENT CHARGES (BILLED) COL. 8	INPATIENT DIRECT COST COL. 9 (7X8)	INDIRECT COST TO CHG. RATIO COL. 10 (6 X 5)	MEDICAID DUAL CHARGE (BILLABLE & NON-BILLABLE UNDER SNF) COL. 11	INPATIENT INDIRECT COST COL. 12 (10 X 11)
41. RADIOLOGY-DIAGNOSTIC												
42. RADIOLOGY-THERAPEUTIC												
43. RADIOISOTOPE												
44. LABORATORY												
45. PBP CLINIC LAB SVC-PRG. ONLY												
46. WHOLE BL. & PK. RED BL. CELLS												
48. IV THERAPY												
49. RESPIRATORY THERAPY												
50. PHYSICAL THERAPY												
51. OCCUPATIONAL THERAPY												
52. SPEECH PATHOLOGY												
53. ELECTROCARDIOLOGY												
54. ELECTROENCEPHALOGRAPHY												
55. MED. SUPPLIES CHG. TO PT.												
56. * DRUGS CHARGED TO PATIENTS												
101 TOTAL												

104 AMOUNT RECEIVED FROM THE MEDICAID PROGRAM (FROM PROGRAM PAID CLAIMS LISTING) _____

105. AMOUNT DUE PROGRAM/PROVIDER (LINE 101, COL. 9 LESS LINE 104) _____

INSTRUCTIONS

1. TOTAL ANCILLARY COSTS FROM HCFA-2552-89, WORKSHEET C, COLUMN 3
2. ALL COST ALLOWABLE UNDER MEDICAID IC/SNF RULES AS DIRECT COST
3. COLUMN 2 DIVIDED BY COLUMN 1
4. ALL OTHER ANCILLARY COST (COLUMN 1 LESS COLUMN 2)
5. COLUMN 4 DIVIDED BY COLUMN 1
6. RATIO OF COST TO CHARGES FROM HCFA-2552-89, WORKSHEET C, COL. 8
7. COLUMN 6 MULTIPLIED BY COLUMN 3
8. DUAL LICENSED CHARGES BILLED TO THE MEDICAID PROGRAM
9. COLUMN 7 MULTIPLIED BY COLUMN 8
10. COLUMN 6 MULTIPLIED BY COLUMN 5
11. ALL DUAL LICENSE CHARGES INCLUDING THOSE CHARGES BILLABLE AND NON-BILLABLE TO THE MEDICAID IC/SNF PROGRAM. SHOULD NOT INCLUDE THOSE CHARGES CONSIDERED TO BE NON-ALLOWABLE COST FOR SERVICES IN A LONG TERM CARE SETTING
12. COLUMN 10 MULTIPLIED BY COLUMN 11. TRANSFER THIS AMOUNT TO KMAP-3, LINE 13

* COST AND CHARGES PRIOR TO OCTOBER 1, 1990 ONLY

KMAP-3

SUPPLEMENTAL MEDICAID SCHEDULE

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR DUAL LICENSED BEDS

VENDOR NAME:

VENDOR NUMBER:

FYB FYE DAYS

*1.	Dual-licensed NF-type Medicaid inpatient days	
2.	Dual-licensed SNF-type Medicaid inpatient days	
3.	Dual-licensed ICF-type Medicaid inpatient days	
*4.	Medicaid rate for dual-licensed NF bed services	
5.	Medicaid rate for dual-licensed SNF bed services	
6.	Medicaid rate for dual-licensed ICF bed services	
*7.	Medicaid payments for dual-licensed NF-type services (Line 1 x Line 4)	
8.	Medicaid payments for dual-licensed SNF-type services (Line 2 x Line 5)	
9.	Medicaid payments for dual-licensed ICF-type services (Line 3 x Line 6)	
10.	Total Medicaid payments for dual-licensed services (Line 7 + Line 8 + Line 9)	
11.	Total Medicaid dual licensed inpatient routine service cost	
12.	Medicaid dual licensed inpatient routine service cost net of dual-licensed payments (Line 11 - Line 10)	
13.	Indirect cost for ancillary services rendered to dual-licensed patients	
14.	Total unreimbursed Medicaid dual license inpatient service cost (Line 12 + Line 13)	

INSTRUCTIONS

Line #

1. From the Medicaid program's Paid Claims Listings
2. From the Medicaid Program's Paid Claims Listings
3. From the Medicaid Program's Paid Claims Listings
13. Transfer from KMAP-2 Line 101, Column 12
14. Line 12 plus line 13. Transfer this amount to HCFA 2552-89, worksheet E-3, Part III, line 7A

* Effective for services provided after October 1, 1990

DISCLOSURE SECTION

VENDOR NAME: ______________________ **FYE** __________

VENDOR NUMBER: __________

A: STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT		

B: PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT			SCHEDULE AND LINE		