

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE
NURSING HOME UNIFORM COST REPORT UNDER TITLE XIX

Exhibit 8

FACILITY DESCRIPTION

Medicaid Provider Number 1. [redacted] National Provider Identifier (NPI) [redacted]

Name of Facility 2. [redacted]

Facility Location - Street Address 3. [redacted] City [redacted] Zip Code [redacted] County [redacted] Phone [redacted]

Federal Employer Identification No 4. [redacted]

Person to contact for questions 5. [redacted] Phone 6. [redacted]

7. Fiscal Year Begin Month Day Year [redacted] 8. Fiscal Year End Month Day Year [redacted] 9. Change in Ownership During Year Yes [redacted] No [redacted] 10. If yes, this Cost Report, For (1) [redacted] Seller (2) [redacted] Buyer

11. Type of Ownership (CHECK ONLY ONE)

Proprietary:

(1) [redacted] Individual
(2) [redacted] Partnership
(3) [redacted] Corporation

Voluntary Non-Profit:

(4) [redacted] Church
(5) [redacted] Other (specify) [redacted]

Government:

(6) [redacted] State
(7) [redacted] County
(8) [redacted] City

12. Attach a copy of financial statements for the cost reporting period

13. If this facility is leased (arms-length), was the facility constructed with the use of Tax Exempt Financing?
Yes [redacted] No [redacted]

IMPORTANT - This report is to be filed with: Myers and Stauffer LC
400 Redland Court
Suite 205
Owings Mills, MD 21117

All applicable information requested in this Uniform Cost Report must be completed in order for it to be accepted by Medicaid.

THE CERTIFICATION ON PAGE 4 MUST BE SIGNED BY AN OFFICER, OWNER OR ADMINISTRATOR OF THE PROVIDER.

ONLY ORIGINAL SIGNATURES WILL BE ACCEPTED

For State Use Only

Receipt Date Original	Receipt Date Other	Edit	
		Date	Editor Initials
		Desk	Verification

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OCCUPANCY AND RATE DATA

PART I - INPATIENT DAYS BY CLASS OF LICENSE

MONTH	1				2		3		4		5		6		7	
	COMPREHENSIVE CARE								NON-COMPREHENSIVE CARE				TOTAL OF FACILITY			
	PRIVATE	MARYLAND MEDICAL ASSISTANCE	MEDICAID HOSPICE	OTHER GOVT.	DOMICILIARY	(SPECIFY)										
1.																
2.																
3.																
4.																
5.																
6.																
7.																
8.																
9.																
10.																
11.																
12.																
12a.																
12b.																
13. TOTALS																

14. Total Comprehensive Care Days
 (Add Line 13, Col. 1, Col. 2, Col. 3 & Col. 4)

PART II - BED CAPACITY

- 15. Licensed beds at beginning of period
- 16. Licensed beds at end of period
- 17. Date(s) of change in number of certified beds, if applicable (month/day)
- 18. Beds Days available during the period

PART III - PERCENT OCCUPANCY

19. Total from Line 13 or 14, Part I divided by Line 18, Part II

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PART IV - DAILY MINIMUM SEMI-PRIVATE RATES AS OF LAST DAY OF REPORTING PERIOD

- 20. Private pay patients
- 21. Medicare patients
- 22. Medicaid patients
- 23. Other (Specify)

24. [REDACTED]

SCHEDULE A

STATEMENT OF OPERATIONS

	1		2	3
	Line	Schedule	PER BOOKS	AS ADJUSTED
REVENUES:				
1. Routine Services	16	B		
2. Special Services	31	B		
3. Less- Allowances and Adjustments	12	C		
4. Net Revenues				
OPERATING EXPENSES:				
5. Nursing Care Service	15	D		
6. Other Patient Care Service	41	E		
7. Routine Service	30	F		
8. Administrative Service	47	G		
9. Capital/Property Service	9	H		
10. Expenses Replaced by Capital Value Rental	16	H		
11. Total Operating Expenses				
12. Gross Profit (Loss) from Operations (Line 4 minus Line 11)				
OTHER NON-OPERATING REVENUES AND NON-REIMBURSABLE EXPENSES:				
13. Non-Operating Revenues	24	I		
14. Non-Reimbursable Expenses	33	I		
15. Net Income (Loss) Before Income Taxes				
16. Provision for Income Taxes				
17. Net Income (Loss) per financial statements				

COST REPORT CERTIFICATION

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 accompanying Cost Report and supporting schedules prepared by _____ for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the Provider(s) in accordance with applicable instructions, except as noted.

OFFICER OR ADMINISTRATOR OF PROVIDER

Name (Please print or type)

Title

Signature

Date

SCHEDULE B

Revenues

ACCOUNT NO.	ROUTINE SERVICE REVENUE	1 PATIENT DAYS	2 BALANCE PER BOOKS	3 REVENUE PER DAY (2/1)
1. 300.01	Comprehensive Care - Private			
2. 302.01	Comprehensive Care - Maryland Medical Assistance (Include patient resources)			
3.	Comprehensive Care - Medicare			
4.	Comprehensive Care - Other Government (specify)			
5.				
6.				
7.	Subtotal - Comprehensive Care (Lines 1 thru 6)			
8.	Other Level (specify)			
9.				
10.				
11.	Other Level (specify)			
12.				
13.				
14.				
15.	Subtotal - Other Levels of Care (Lines 8 thru 14)			
16.	TOTAL ROUTINE SERVICE REVENUE (Line 7 plus Line 15)			

(Page 3 (Schedule A,
 Line 13) Line 1)

ACCOUNT NO.	SPECIAL SERVICE (ANCILLARY REVENUE)	BALANCE PER BOOKS
17. 440.01	Physician Care	
18. 405.01	Physical Therapy	
19. 410.01	Pharmacy	
20. 415.01	Speech Therapy	
21. 420.01	Laboratory	
22. 430.01	Radiology	
23. 435.01	Oxygen	
24. 450.01	Recreational Activities	
25. 455.01	Medical Supplies	
26. 460.01	Equipment Rental	
27.	Occupational Therapy	
28.		
29.		
30.	Total From Any Attachments	
31.	TOTAL SPECIAL SERVICE REVENUES	

(Schedule A,
 Line 2)

SCHEDULE C

Revenues

ACCOUNT NO.	ALLOWANCES AND ADJUSTMENTS TO REVENUES	BALANCE PER BOOKS
1. 513.01	Charity Service - Comprehensive Care	
2. 513.01	Charity Service - Other	
3. 511.01	Contractual Allowance - Other - Medicare	
4. 512.01	Contractual Allowance - Other - Medical Assistance	
5. 512.01	Contractual Allowance - Comprehensive Care - Medical Assistance	
6.	Contractual Allowance - Comprehensive Care - Medicare	
7. 514.01	Administrative Adjustment	
8. 510.00	Provision for Doubtful Accounts/Bad Debts	
9. 511.01	Prior Year Settlements - Medicare	
10. 512.01	Prior Year Settlements - Medical Assistance	
11.		
12.	TOTAL ALLOWANCES AND ADJUSTMENTS	

Schedule A, Line 3

SCHEDULE D

NURSING CARE SERVICE

ACCOUNT NO.	NURSING CARE SERVICE	1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J,L,M,N)	3 AS ADJUSTED
1. 600.10	Salaries and Wages			
2. 600.20	Supplies			
3. 600.90	Contracted Services			
4. 735.20	Oxygen			
5.	Tube Feeding Supplements			
6.				
7.	Employee Benefits (Schedule L) *			
8. a.	Adjustments not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
9.	TOTAL NURSING CARE SERVICE			

* This must include Vacations, Holidays, and Sick Pay, applicable to Nursing Care Service

ACCOUNT NO.	NON-REIMBURSABLE SERVICES - PERSONAL NURSING	1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J,L,M,N)	3 AS ADJUSTED
10. 650.10	Salaries and Wages			
11. 650.20	Other			
12.	Total			
13.	Employee Benefits (Schedule L)			
14.	Total Non-Reimbursable Service			

15. Total, This Schedule (Lines 9 + 14)			
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(Schedule A, Line 5)

(Schedule A, Line 5)

SCHEDULE E

OTHER PATIENT CARE SERVICE

ACCOUNT NO.		1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J,L,M,N)	3 AS ADJUSTED
	MEDICAL DIRECTOR ADMINISTRATIVE EXPENSE			
1. 700.10	Salaries and Wages			
2. 700.20	Supplies			
3. 700.90	Contracted Service			
	PHYSICAL THERAPY EXPENSE			
4. 705.10	Salaries and Wages			
5. 705.20	Supplies			
6. 705.90	Contracted Service			
	PHARMACY EXPENSE			
7. 710.10	Salaries and Wages			
8. 710.20	Supplies (In-house Pharmacy only)			
9. 710.90	Contracted Service			
10. 710.21	Over-the-Counter Drugs			
11. 710.22	Prescription Drugs			
	SPEECH THERAPY EXPENSE			
12. 715.10	Salaries and Wages			
13. 715.20	Supplies			
14. 715.90	Contracted Service			
	LABORATORY EXPENSE			
15. 720.10	Salaries and Wages			
16. 720.20	Supplies			
17. 720.90	Contracted Service			
	RADIOLOGY EXPENSE			
18. 730.10	Salaries and Wages			
19. 730.20	Supplies			
20. 730.90	Contracted Service			
	RECREATIONAL ACTIVITIES EXPENSE			
21. 740.10	Salaries and Wages			
22. 740.20	Supplies			
23. 740.90	Contracted Service			
	OCCUPATIONAL THERAPY EXPENSE			
24. 745.10	Salaries and Wages			
25. 745.20	Supplies			
26. 745.90	Contracted Service			
	SOCIAL SERVICES EXPENSE			
27. 840.10	Salaries and Wages			
28. 840.20	Supplies			
29. 840.90	Contracted Service			
	RELIGIOUS SERVICES EXPENSE			
30. 845.10	Salaries and Wages			
31. 845.20	Supplies			
32. 845.90	Contracted Service			
33. 803.20	Food Cost- Raw Food *			
34a. 781.00	Barber and Beauty Shop Salary			
34b.	Barber and Beauty Shop Other			
	OTHER (Specify):			
35.				
36.				
37.				
38.				
39.	Employee Benefits (Schedule L)			
40. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
41.	TOTAL OTHER PATIENT CARE SERVICE			

* Exclude food supplements used in tube feedings

(Schedule A, Line 6)

(Schedule A, Line 6)

SCHEDULE F

ROUTINE SERVICES

ACCOUNT NO.		1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J,L,M,N)	3 AS ADJUSTED
	DIETARY (Include Raw Food at Schedule E, Line 33)			
1. 800.10	Salaries and Wages			
2. 800.20	Supplies			
3. 800.90	Contracted Services			
4.	Other (Specify):			
5. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
6.	TOTAL DIETARY EXPENSE			
	LAUNDRY			
7. 810.10	Salaries and Wages			
8. 810.20	Supplies			
9. 810.90	Contracted Services			
10. 810.50	Linen Replacement			
11.	Other (Specify):			
12. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
13.	TOTAL LAUNDRY EXPENSE			
	HOUSEKEEPING			
14. 820.10	Salaries and Wages			
15. 820.20	Supplies			
16. 820.90	Contracted Services			
17.	Other (Specify):			
18. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
19.	TOTAL HOUSEKEEPING EXPENSE			
	OPERATION AND MAINTENANCE OF PLANT			
20. 830.10	Salaries and Wages			
21. 830.20	Supplies			
22. 830.40	Repairs and Maintenance			
23. 830.90	Contracted Services			
24. 830.60	Utilities			
25. 830.45	Minor Equipment Expense			
26.	Other (Specify):			
27. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
28.	TOTAL OPERATION AND MAINTENANCE			
29.	Employee Benefits (Schedule L)			
30.	TOTAL ROUTINE SERVICES (Lines 6+13+19+28+29)			

(Schedule A, Line 7)

(Schedule A, Line 7)

SCHEDULE G

ADMINISTRATIVE SERVICE

ACCOUNT NO.	ADMINISTRATIVE AND GENERAL	1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J,L,M,N)	3 AS ADJUSTED
ADMINISTRATIVE EXPENSES				
1. 860.10	Salaries and Wages - Administrators			
2. 860.11	Salaries and Wages - Office Staff			
3. 860.20	Supplies			
4. 860.90	Management Services			
5. 860.91	Central Office Overhead			
6. 860.75	Insurance - Non-Property			
7. 860.76	Taxes on Inventory; Licenses			
8. 860.88	Auto Expense			
9. 860.81	Legal			
10. 860.80	Accounting			
11. 860.70	Dues and Subscriptions			
12. 860.86	Travel			
13. 860.85	Communications			
14. 860.94	Entertaining			
15. 860.25	Data Processing			
16. 871.00	Employee Benefits			
17. 985.07	Amortization - Start-up Costs			
18. 985.07	Amortization - Organization Costs			
19.	Other (Specify):			
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.	Subtotal (Lines 1-29)			
MEDICAL RECORDS EXPENSE				
31. 795.10	Salaries and Wages			
32. 795.20	Supplies			
33. 795.90	Contracted Services			
34.	Subtotal (Lines 31-33)			
TRAINING				
35. 850.10	Salaries and Wages			
36. 850.20	Supplies			
37.	Contracted Services			
38.	Subtotal (Lines 35-37)			
DEPRECIATION & INTEREST				
39. 860.87	Depreciation - Transportation Equipment *			
40. 980.04	Interest Expense - Working Capital and Auto Loans (Schedule V, Column 7-8)			
QUALITY ASSURANCE				
41.	Salaries & Wages			
42.	Supplies			
43.	Contracted Services			
44.	Subtotal (Lines 41-43)			
45.	Employee Benefits (Schedules L, M)			
46. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustment (Schedule N)			
47.	TOTAL ADMINISTRATIVE SERVICE (Sum of Lines 30, 34, 38, 39, 40, 44, 45, & 46)			

* (Schedule U, Column 3, Line 6)

(Schedule A, Line 8)

(Schedule A, Line 8)

SCHEDULE H

CAPITAL / PROPERTY SERVICE

ACCOUNT NO.	RECURRING COSTS	1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J, M & N)	3 AS ADJUSTED
1. 980.02	Interest on Real Estate *			
2. 980.02	Interest on Major Equipment *			
3. 844.00	Taxes on Real Estate			
4. 844.00	Other Property Taxes			
5. 848.00	Insurance on Real Estate			
6. 848.00	Insurance on Major Equipment			
7. 980.02	Amortization - Mortgage Acquisition Costs			
8. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustments (Schedule N)			
9. Total Recurring Capital/Property Service				

(Schedule A, Line 9)

(Schedule A, Line 9)

ACCOUNT NO.	REPLACED COSTS	1 BALANCE PER BOOKS	2 ADJUSTMENTS (SCHEDULES J, M & N)	3 AS ADJUSTED
10. 900.02	Depreciation - Real Estate *			
11. 900.03	Depreciation - Major Equipment *			
12. 901.02	Rental - Real Estate *			
13. 901.04	Rental - Major Equipment *			
14. 900.05	Amortization - Leasehold Improvements *			
15. a.	Adjustments Not Related to Specific Accounts (Schedules J & M)			
b.	Allocation Adjustment (Schedule N)			
16. Total Expenses Replaced by Capital Value Rental				

(Schedule A, Line 10)

(Schedule A, Line 10)

*Note
 Lines 1 and 2 must be supported by Schedule V, Columns 9-10.
 Lines 10, 11 and 14 must be supported by Schedule U, Column 3.
 Lines 12 and 13 must be supported by Schedule W, Line 6, Columns 4-5.

SCHEDULE I

NON-OPERATING REVENUES AND NON-REIMBURSABLE EXPENSES

ACCOUNT NO.	OTHER REVENUES	PER BOOKS
1. 475.01	Employee and Guest Meals	
2. 477.01	Grants, Endowments and Trusts	
3. 476.01	Donated Services	
4. 476.01	Donated Commodities	
5. 487.01	Coffee Shop and Vending	
6. 480.01	Television Charges	
7. 481.01	Beauty and Barber Shop	
8. 482.01	Laundry Income	
9. 480.01	Telephone and Telegraph	
10. 485.01	Activities Program Income	
11. 486.01	Personal Purchases	
12. 490.01	Sales - Canteen and Gift Shop	
13. 493.01	Uniform Sales	
14. 491.01	Rental Income (Sub-Lease, etc.)	
15.a. 492.00	Interest Income: Restricted (492.01)	
15.b. 492.00	Interest Income: Unrestricted (492.02)	
16. 494.01	Investment Income	
17. 495.01	Gain or Loss on Sale of Assets	
18. 496.01	Management Fees	
19. 497.01	Discounts Earned	
20.	Miscellaneous Income- Specify on Lines 20-23, if significant	
21.		
22.		
23.		
24.	TOTAL NON-OPERATING REVENUES (Schedule A, Line 13)	

ACCOUNT NO.	NON-REIMBURSABLE EXPENSES	PER BOOKS
25. 787.00	Coffee Shop and Vending Machines (if Schedule N is not required)	
26. 959.01	Contributions	
27. 790.00	Canteen and Gift Shop (if Schedule N is not required)	
28. 788.00	Parking	
29. 913.90	Utilization Review	
30. 860.35	Advertising other than employment ads	
31. 770.	Day Care (if Schedule N is not required)	
32.	Total From Any Attachments	
33.	TOTAL NON-REIMBURSABLE EXPENSES (Schedule A, Line 14)	

SCHEDULE J

ADJUSTMENT TO EXPENSES

	1	2	3		4
	BASIS *	AMOUNT	FORWARD TO SCHEDULE	LINE	CLARIFYING COMMENTS
1. Television and Telephone					
2.					
3. Sale of meals to other than patients					
4. Vending machine					
5. Prescription drugs					
6. Sale of drugs and supplies to other than patients					
7. Sale of scrap, waste, etc.					
8. Purchase discounts					
9. Rebates and refunds					
10. Bad debts					
11. Interest income on unrestricted funds					
12.a. Physical Therapy - Salaries and Wages			E	4	
12.b. Physical Therapy - Supplies			E	5	
12.c. Physical Therapy - Contracted Service			E	6	
13. Physician's medical and dental services					
14. Depreciation - Non-Patient Care					
15. Excessive depreciation					
16. Advertising					
17. Gain or loss on sale of assets					
18. Personal expenses - other					
19. Cost of lodging rented or provided owners/employees					
20. Interest expense - non-patient care related					
21.a. Speech therapy - Salaries and Wages			E	12	
21.b. Speech Therapy - Supplies			E	13	
21.c. Speech Therapy - Contracted Service			E	14	
22. EKG					
23. Contributions					
24.a. Occupational Therapy - Salaries and Wages			E	24	
24.b. Occupational Therapy - Supplies			E	25	
24.c. Occupational Therapy - Contracted Service			E	26	
25. Public Relations					
26. Rental of space					
27. Fund Raising costs					
28. Grants and Gifts designated by Donor for specific expenses					
29. Eyeglasses, dentures, and appliances					
30.a. Laboratory - Salaries and Wages			E	15	
30.b. Laboratory - Supplies			E	16	
30.c. Laboratory - Contracted Service			E	17	
30.d. Radiology - Salaries and Wages			E	18	
30.e. Radiology - Supplies			E	19	
30.f. Radiology - Contracted Service			E	20	
31. Over-the-counter drugs in excess of allowable					
32. Owner's (relative's) compensation in excess of allowable					
33. Related organization substitution					(Attach Details)
34. Management fees to related parties **					
35.					
36.					
37. TOTAL					

* A = Cost, B = Revenue

** See Schedule M for inclusion of actual costs

SCHEDULE J-1

ADJUSTMENT TO EXPENSES

	1	2	3		4
	BASIS *	AMOUNT	FORWARD TO SCHEDULE	LINE	CLARIFYING COMMENTS
37. Brought Forward					
38.					
39.					
40.					
41.					
42.					
43.					
44.					
45.					
46.					
47.					
48.					
49.					
50.					
51.					
52.					
53.					
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71.					
72.					
73.					
74.					
75.					
76.					
77.					
78.					
79.					
80.					
81.					
82.					
83.					
84. TOTAL					

* A = Cost, B = Revenue

SCHEDULE J-2

ADJUSTMENT TO EXPENSES

	1	2	3		4
	BASIS *	AMOUNT	FORWARD TO SCHEDULE	LINE	CLARIFYING COMMENTS
84. Brought Forward					
85.					
86.					
87.					
88.					
89.					
90.					
91.					
92.					
93.					
94.					
95.					
96.					
97.					
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116.					
117.					
118.					
119.					
120.					
121.					
122.					
123.					
124.					
125.					
126.					
127.					
128.					
129.					
130.					
131. TOTAL					

* A = Cost, B = Revenue

SCHEDULE K

OWNER AND ADMINISTRATOR COMPENSATION

FULL OWNERSHIP DISCLOSURE MUST BE MADE REGARDLESS OF
WHETHER COMPENSATION IS INCLUDED IN REPORT

Owners

Name	Title and Function	SOLE PROPRIETOR-SHIP		PARTNERS		CORPORATE OFFICERS		Total Compensation for the Period (A), (B)			
		Percentage of Customary Work Week Devoted to		Percent Share of Operating Profit or (Loss)	Percentage of Customary Work Week Devoted to		Percent of Provider's Stock Owned	Percentage of Customary Work Week Devoted to		Reported at Schedule-Line	
		This Facility	Other Organizations		This Facility	Other Organizations		This Facility	Other Organizations		Amount
(1)	(2)	(3)		(4a)	(4b)		(5a)	(5b)		(6)	(7)
1.											
2.											
3.											
4.											
5.											

(A) Compensation as used in this schedule has the same definition as in Reg. Sec. 405.426, "Compensation of Owners" of the Principles of Reimbursement for Provider Costs. (B) Include all fringe benefits.

Administrators and/or Assistant

Administrators (Other than Owners)

Name	Title	Percentage of Customary Work Week Devoted to	Percentage of Customary Work Week Devoted to		Total Compensation for the Period (A), (B)	
			This Facility	Other Organizations	Amount	Reported at Schedule-Line
(8)	(9)	(10)	(11)	(12)	(11)	(12)
6.						
7.						
8.						

Relatives of Owner

Name and Relationship to Owner	Title	Percentage of Customary Work Week Devoted to	Percentage of Customary Work Week Devoted to		Total Compensation for the Period (A), (B)	
			This Facility	Other Organizations	Amount	Reported at Schedule-Line
(13)	(14)	(15)	(16)	(17)	(16)	(17)
9.						
10.						
11.						
12.						
13.						
14.						

NOTE: Attach details where necessary

SCHEDULE L

EMPLOYEE BENEFITS

EXPENSE CONTENT	871.00	1 PER BOOKS	2 ADJUSTMENTS (Schedules J & M)	3 AS ADJUSTED
1. F.I.C.A.				
2. State and Federal Unemployment Insurance				
3. Group Health Insurance				
4. Group Life Insurance				
5. Pension and Retirement				
6. Workers' Compensation Insurance				
7. Union Health and Welfare				
8. Vacations, Holidays and Sick Pay				
9. Employee Benefits - Not payroll-related				
10.				
11. TOTAL (SCHEDULE G, LINE 16)				

4 EXPENSE ALLOCATION	5 TO LINE	6 TO SCHEDULE	7 GROSS SALARIES	7a ADJUSTMENTS	7b ADJ. GROSS SALARIES	8a NON-ALLOWABLE EMP. BENEFITS	8b ALLOWABLE EMP. BENEFITS
12. Nursing Care Service	7	D					
13. Personal Nursing	13	D					
14. Medical Director Administrative Expense							
15. Physical Therapy							
16. Pharmacy							
17. Speech Therapy							
18. Laboratory							
19. Radiology							
20. Recreational Activities							
21. Occupational Therapy							
22. Social Services							
23. Religious Services							
24. Barber and Beauty Shop							
25. Other							
26. TOTAL OTHER PATIENT CARE SERVICES	39	E					
27. Dietary							
28. Laundry							
29. Housekeeping							
30. Plant Operation & Maintenance							
31. TOTAL ROUTINE SERVICE	29	F					
32. Administrative							
33. Medical Records							
34. Training							
35. Quality Assurance							
36. TOTAL ADMINISTRATIVE SERVICE	45	G					
37. Gift Shop							
38. Coffee Shop							
39. Other							
40. TOTAL NON-REIMBURSABLE EXPENSE							
41. TOTALS							
42. TOTAL OF LINE 41, COLUMN 8A & 8B							

(Line 42, Column 8 must agree with
Column 3, Line 11)

SCHEDULE M

CENTRAL OFFICE OVERHEAD

	1 TOTAL AMOUNT	2 % ALLOCATED TO THIS FACILITY	3 ALLOCATION BASIS	4 COST ALLOCATED TO THIS FACILITY	5 REPORT AT SCHED. LINE	
SALARIES					COLUMN 2	
1. Owners/Officers						
2. Managers					G	1
3. Clerical					G	2
4. Other						
OTHER EXPENSES						
5. Supplies						
6. Accounting					G	10
7. Advertising					G	
8. Auto Expense					G	8
9. Consultants						
10. Data Processing					G	15
11. Depreciation - Real Estate					H	8a
12. Depreciation - Equipment					H	8a
13. Dues and Subscriptions					G	11
14. Employee Benefits					G	45
15. Employee Recruiting					G	
16. Insurance - Real Estate					H	5
17. Insurance - Other						
18. Interest - Real Estate					H	1
19. Interest - Equipment					H	2
20. Legal					G	9
21. Licenses					G	7
22. Maintenance & Repairs					F	22
23. Office Supplies					G	3
24. Rent - Real Estate					H	8a
25. Rent - Equipment					H	8a
26. Seminars & Training					G	
27. Taxes - Real Estate					H	3
28. Taxes - Personal Property					H	4
29. Telephone					G	13
30. Travel					G	12
31. Utilities					F	24
32. Other (Specify)						
33.						
34.						
35.						
36.						
37.						
38.						
39.						
40.						
41.						
TOTALS						

Provider No.
 Period Ending 1/0/1900

SCHEDULE N

ALLOCATION OF EXPENSES TO NON-PATIENT CARE AREAS

Expenses To Be Allocated	1 Balance Per Books Sch. D-H, Col.1	2a Adjustments from Schedules J & M Sch. D-H, Col.2	2b Adjustments from Schedule L		2c Amount	3 Costs as Adjusted (Col. 1 & 2a & 2c)	3a Adjustments	3b Final Adjusted Costs	4 NON-COMPREHENSIVE ACTIVITIES			7	
			Reference Line No.	Sch. L, Col. 8					Percentage From Sch. N, Page 19, Col. 10	Costs Allocated Col. 3 x Col. 4	Forward to Col. 2		
											Schedule		Line
1. Nursing Care													
2. Medical Director			12								D	8b	
3. Physical Therapy			14								E	40b	
4. Pharmacy			15										
5. Speech Therapy			16								E	40b	
6. Laboratory			17										
7. Radiology			18										
8. Recreation			19										
9. Occupational			20								E	40b	
10. Social Service			21										
11. Religious			22								E	40b	
12. Food			23								E	40b	
13. Barber and Beauty Shop Salary			24								E	40b	
14. Barber and Beauty Shop Other			--								E	40b	
15.			--								E	40b	
16.			--								E	40b	
17.			--								E	40b	
18.			--								E	40b	
19. Employee Benefits - Sch. E, Line 39			26								E	40b	
20. Non-Specific Adj. - Sch. E, Line 40a			--										
21. Dietary			27								F	5b	
22. Laundry			28								F	12b	
23. Housekeeping			29								F	18b	
24. Operation & Maintenance			30								F	27b	
25. Employee Benefits - Sch. F, Line 29			--										
26. Medical Records			33								G	46b	
27. Training			34								G	46b	
28. Depreciation - Transp. Equip.			--								G	46b	
29. Interest (G-40)			--								G	46b	
30. Quality Assurance			35								G	46b	
31. Employee Benefits - Sch. G, Line 45			--								G	46b	
32. Interest, Taxes, Insurance			--								H	8b	
33. Depreciation, Rental, Amortization			--								H	15b	
34. Other (Specify)													
35.													
36.													
37.													
38.													
39. Sub-Total													
40. Administration			32								G	46b	
41. TOTAL													

Provider No.
 Period Ending 1/0/1900

SCHEDULE N

STATISTICAL BASIS FOR ALLOCATION OF EXPENSES TO NON-PATIENT CARE AREAS

NON-COMPREHENSIVE CARE AREAS STATISTICS											
ALLOCATION OF COSTS	Statistical Basis	1 Domiciliary	2 Gift Shop	3 Coffee Shop -- Vending	4 Rental - Sublease, etc.	5 Other (Specify)	6 Other (Specify)	7 Total (Columns 1-6)	8 Comprehensive Care	9 Total Basis All Activities	10 Percentage Applicable To Non-Comp. Areas (Col. 7 / Col. 9) To Page 18 Col. 4
1. Nursing Care	Direct Cost										
2. Medical Director	Patient Days										
3. Physical Therapy	Patient Days										
4. Pharmacy											
5. Speech Therapy											
6. Laboratory											
7. Radiology											
8. Recreation	Patient Days										
9. Occupational											
10. Social Service	Patient Days										
11. Religious	Patient Days										
12. Food	Meals Served										
13. Barber and Beauty Shop Salary											
14. Barber and Beauty Shop Other											
15.											
16.											
17.											
18.											
19. Employee Benefits - Sch. E, Line 39											
20. Non-Specific Adj. - Sch. E, Line 40a											
21. Dietary	Meals Served										
22. Laundry	Pounds										
23. Housekeeping	Square Feet										
24. Operation & Maintenance	Square Feet										
25. Employee Benefits - Sch. F, Line 28											
26. Medical Records	Patient Days										
27. Training	Patient Days										
28. Depreciation - Transp. Equip.	Patient Days										
29. Interest (G-40)	Square Feet										
30. Quality Assurance	Patient Days										
31. Employee Benefits - Sch. G, Line 45											
32. Interest, Taxes, Insurance	Square Feet										
33. Depreciation, Rental, Amortization	Square Feet										
34. Other (Specify):											
35.											
36.											
37.											
38.											
39. Sub-Total											
40. Administration											
41. TOTAL	Accum. Cost						(1)			(2)	

(1) Per Page 18, Column 5, Line 39
 (2) Per Page 18, Column 3b, Line 39

SCHEDULE O

SERVICES FROM RELATED PARTIES

1. In the costs to be reimbursed by the Maryland Medical Assistance Program, are any costs included which result from transactions with a related party as defined in Chapter 10 of PRM Part I (HIM-15)?

Yes No (if yes, complete the section below)

N/A IS NOT AN APPROPRIATE RESPONSE.

2. List all related parties for which the answer to 1. above is yes, and provide the information indicated:

	1 RELATED PARTY	2 FORM OF RELATIONSHIP	3 TYPE SERVICE/SUPPLY	4 AMOUNT	5 REPORTED AT	
					Schedule	Line
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Provider No.
 Period Ending 1/0/1900

SCHEDULE P

ANALYSIS OF CAPITAL

1	2	3	4	5
		CAPITAL	CUMULATIVE EARNINGS (DEFICIT)	TOTAL CAPITAL
1. Beginning of Period, Per Books				
2. Dividends and/or Drawings				
Date	Explanation			
1)				
2)				
3)				
4)				
3. Additional Capital				
Date	Explanation			
1)				
2)				
3)				
4)				
4. Other				
Date	Explanation			
1)				
2)				
3)				
4)				
5. Net Income (Loss) for the period (Sch. A, Col. 2, Line 17)				
6. End of Period, Per Books				

VOLUNTARY NON-PROFIT AND GOVERNMENT FACILITIES ONLY

Provider No.

Period Ending 1/0/1900

SCHEDULE Q

ANALYSIS OF FUND BALANCES

LINE NO.	UNRESTRICTED FUND			EXTERNALLY RESTRICTED FUNDS		
	(1) RETAINED FOR GENERAL PURPOSES	(2) INVESTED IN PROPERTY AND EQUIPMENT	(3) TOTAL	(4) PLANT REPLACEMENT AND EXPANSION PROGRAM	(5) SPECIFIC PURPOSES	(6) ENDOWMENT
1.	BALANCE AT BEGINNING OF YEAR, AS PREVIOUSLY REPORTED					
2.	Restatement (Describe):					
3.						
4.						
5.						
6.	BALANCE AT BEGINNING OF YEAR, as restated					
7.	Additions (Deductions):					
	Net Income (Loss) Schedule A, Col. 2, Line 17					
8.						
9.						
10.						
11.	Contributions and Grants					
12.	Investment Income					
13.	Expenditures for Specific Purposes					
14.						
15.	Donated Property, Plant & Equipment					
16.	Other (Describe)					
17.	TOTAL ADDITIONS (DEDUCTIONS)					
	Transfers:					
18.	Contributions and Grants					
19.	Property and Equipment Additions					
20.	Principal Payments on Long-Term Debt					
21.	Cash Appropriated for Future Expansion					
22.	Equipment, Retired					
23.	Provision for Depreciation					
24.	Other (Describe)					
25.						
26.	TOTAL TRANSFERS					
27.	BALANCE END OF YEAR					

Provider No.
 Period Ending 1/0/1900

SCHEDULE R

BALANCE SHEET

ASSETS:		ACCOUNT NUMBER	AMOUNT PER BOOKS	TOTALS
CURRENT ASSETS:				
1. Cash		100		
2. Patient Accounts Receivable (Less Allowance for Bad Debts)		120		
3. Other Accounts Receivable (Excluding Owners or Related Parties)		126		
4. Inventories		130		
5. Prepaid Expenses		140		
6. Interest Receivable		127		
7. Medicare-Medicaid Final Settlement Receivable		129		
8. Other Current Assets (Itemize)				
9.				
				Lines 1 - 10
10.				
FIXED ASSETS:				
	Historical Cost	Accumulated Depreciation		
	Schedule T	Schedule U		Line 11
11. FIXED ASSETS:				
INVESTMENTS AND OTHER ASSETS				
	HISTORICAL COST	ACCUMULATED AMORTIZATION		
12. Organization Expenses			198	
13. Goodwill - Purchased			199	
14. Deferred Charges			195	
15. Escrow Deposits			190	
16. Investments (Itemize)				
17.				
18.				
19. Loans to Owners or Related Parties (Schedule V)			113	
20. Other Assets (Itemize):				
21.				
				Lines 12 - 22
22.				
23. Total Assets				
(Sum of Lines 10, 11 and 22)				

Provider No.
 Period Ending 1/0/1900

SCHEDULE R

BALANCE SHEET

LIABILITIES: CURRENT LIABILITIES:	ACCOUNT NUMBER	AMOUNT PER BOOKS	TOTALS
24. Trade Accounts Payable	200		
25. Notes Payable (Schedule V)	210		
26. Accrued Payroll (Exclude Owners or Stockholders)	220		
27. Accrued Payroll (Owners or Stockholders)	220		
28. Accrued Payroll Taxes Payable	230		
29. Accrued Income Taxes	243		
30. Medicare-Medicaid Final Settlement Payable	265		
31. Medicare Current Financing Payable	264		
32. Interest Payable	260		
33. Other Current Liabilities (Itemize)			
34.			
			Lines 24 - 35
35.			
LONG-TERM LIABILITIES:			
36. Notes Payable - (Schedule V)	270		
37. Other Long-Term Liabilities (Itemize)			
			Lines 36 - 38
38.			
CAPITAL (Schedule P)			
39. Owners Capital	290		
40. Capital Stock	290		
41. Treasury Stock	290		
			Lines 39 - 42
42. Cumulative Earnings	295		
43. TOTAL LIABILITIES AND FUND CAPITAL (Sum of Lines 35, 38 and 42)			

Provider No.
 Period Ending 1/0/1900

SCHEDULE S

BALANCE SHEET - UNRESTRICTED FUND

ASSETS:		ACCOUNT NUMBER	AMOUNT PER BOOKS	TOTALS
<u>CURRENT ASSETS:</u>				
1.	Cash	100		
2.	Patient Accounts Receivable (Less Allowance for Bad Debts)	120		
3.	Due from Restricted Funds	125		
4.	Inventories	130		
5.	Prepaid Expenses	140		
6.	Interest Receivable	127		
7.	Medicare-Medicaid Final Settlement Receivable	129		
8.	Other Current Assets (Itemize)	126		
9.				
				Lines 1 - 10
10.				
		Historical Cost	Accumulated Depreciation	
		Schedule T	Schedule U	Line 11
11.	FIXED ASSETS:			
INVESTMENTS AND OTHER ASSETS		HISTORICAL COST	ACCUMULATED AMORTIZATION	
12.	Organization Expenses		198	
13.	Goodwill - Purchased		199	
14.	Deferred Charges		195	
15.	Escrow Deposits		190	
16.	Investments (Itemize)			
17.				
18.				
19.	Loans to Owners or Related Parties (Schedule V)	113		
20.	Other Assets (Itemize):			
21.				
				Lines 12 - 22
22.				
23.	Total Assets (Sum of Lines 10, 11 and 22)			

Provider No.
 Period Ending 1/0/1900

SCHEDULE S

BALANCE SHEET - UNRESTRICTED FUND

LIABILITIES: CURRENT LIABILITIES:	ACCOUNT NUMBER	AMOUNT PER BOOKS	TOTALS
24. Trade Accounts Payable	200		
25. Notes Payable (Schedule V)	210		
26. Accrued Payroll	220		
27. Medicare Current Financing	264		
28. Accrued Payroll Taxes Payable	230		
29. Due to Restricted Funds	225		
30. Medicare-Medicaid Final Settlement Payable	265		
31. Interest Payable	260		
32. Other Current Liabilities (Itemize)	260		
33.			
			Lines 24 - 34
34.			
LONG-TERM LIABILITIES:			
35. Notes Payable - (Schedule V)	270		
36. Other Long-Term Liabilities (Itemize)			
			Lines 35 - 37
37.			
			Line 38
38. Unrestricted Fund Balance	299		
39. TOTAL LIABILITIES AND FUND BALANCE (Sum of Lines 34, 37 and 38)			

VOLUNTARY NON-PROFIT AND GOVERNMENT FACILITIES ONLY

Provider No.

Period Ending 1/0/1900

SCHEDULE S

BALANCE SHEET - EXTERNALLY RESTRICTED FUNDS

LINE NO.	ASSETS	ACCOUNT NUMBER	AMOUNT PER BOOKS	LIABILITIES AND FUND BALANCES	ACCOUNT NUMBER	AMOUNT PER BOOKS
	PLANT REPLACEMENT AND EXPANSION FUNDS			PLANT REPLACEMENT AND EXPANSION FUNDS		
1.	Cash	100		21. Due to Other Funds	225	
2.	Investments, at cost: Marketable Securities	110		22. Other Liabilities (Itemize):		
3.	Other	112				
4.	Receivables, Net of Estimated Uncollectible Amounts	126				
5.	Due From Other Funds	125				
6.	Other Assets			23. Fund Balance	299	
7.	TOTAL ASSETS			24. TOTAL LIABILITIES AND FUND BALANCE		
	SPECIFIC PURPOSE FUNDS			SPECIFIC PURPOSE FUNDS		
8.	Cash	100		25. Due to Other Funds	225	
9.	Marketable Securities at Cost	110		26. Other Liabilities (Itemize):		
10.	Receivables, Net of Estimated Uncollectible Amounts	126				
11.	Due From Other Funds	125				
12.	Other Assets			27. Fund Balance	299	
13.	TOTAL ASSETS			28. TOTAL LIABILITIES AND FUND BALANCE		
	ENDOWMENT FUNDS			ENDOWMENT FUNDS		
14.	Cash	100		29. Mortgages	270	
15.	Investments, at cost: Marketable Securities	110		30. Other Liabilities (Specify)		
16.	Other	112		31. Due to Other Funds	225	
17.	Receivables, Net of Estimated Uncollectible Amounts	126		32. Other Liabilities (Itemize)		
18.	Due From Other Funds	125				
19.	Other Assets			33. Fund Balance	299	
20.	TOTAL ASSETS			34. TOTAL LIABILITIES AND FUND BALANCE		

SCHEDULE T

ANALYSIS OF FIXED ASSETS

1	ACCOUNT NUMBER	2 BEGINNING BALANCE	3 ADDITIONS	4 DISPOSALS	5 ENDING BALANCE
1. Land	160.00				
2. Land Improvements	162.10				
3. Buildings	166.10				
4. Leasehold Improvements	166.10				
5. Building Improvements	168.10				
6. Movable Equipment & Furniture	170.10				
7. Motor Vehicles	184.10				
8. Other (Specify)					
9.					
10. Subtotal					
11. Capitalized Leases	168.10				
12. TOTAL FIXED ASSETS					

Assets Not Related To Patient Care Included in Above (Specify):					Sch. R	Sch. S
					Line 11	or Line 11
13.						
14.						
15.						
16. TOTAL						

LISTING OF ADDITIONS

List All Additions Over \$5,000

	ACCOUNT NO.	DESCRIPTION	AMOUNT
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24. Total From Any Attachments			
25. Total Additions Less Than \$5,000 Each			
26. Total Additions For The Year			

SCHEDULE U

ANALYSIS OF DEPRECIATION EXPENSE

1	ASSET ACCOUNT NUMBER	2 BEGINNING BALANCE	3 DEPRECIATION FOR THE YEAR	4 ACCUMULATED DEPRECIATION ON DISPOSALS	5 ENDING BALANCE	6 DEPRECIATION CARRIED FORWARD TO	
						SCHED.	LINE
1. Land Improvements	162.10				0	H	10
2. Buildings	166.10				0	H	10
3. Leasehold Improvements	186.10				0	H	14
4. Building Improvements	168.10				0	H	10
5. Movable Equipment & Furniture	170.10				0	H	11
6. Motor Vehicles	184.10				0	G	39
7. Other (Specify)					0		
8.					0		
9.					0		
10. Subtotal		0	0	0	0		
11. Capitalized Leases	188.10				0		
12. TOTAL	189.10	0	0	0	0		

Assets Not Related to Patient Care Included in Above (Specify)	Sch. R Line11	Sch. S Line11
13.	0	
14.	0	
15.	0	
16.	0	
17.	0	
18. TOTAL	0	0

Provider No.
 Period Ending 1/0/1900

SCHEDULE V

DEBT, INTEREST EXPENSE AND INTEREST REVENUE

1 Payable to (Indicate Related Party by Asterisk (*))	2 Date of Loan Month/Year	3 Ending Balance	4 Included At Sch. R Sch. S Line	5 Purpose of Loan	6 Interest Rate	7 Maturity Date	8 Interest Expense for Period			10
							9 Autos & Working Capital		10 Property Related	
							11 Related Party	12 Non Related		
1.										
2.										
3.										
4.										
5.										
6.										
7. Total From Any Attachments										
8. TOTAL										

(Schedule G, Line 40) (Schedule H, Line 1) (Schedule I, Line 15)

NOTE: Loan agreements and amortization schedules for any new loans during the Cost Report period must be submitted with the Cost Report.

- This schedule is designed to provide information on existing debt.
- Total Interest Expense should agree with the amounts reflected in Schedules G and H.
- It may be necessary to list information on loans paid off during the year to provide all the details of Interest Expense for the year.
- No amounts should be included in Column 3 for loans paid off.
- Include debt/interest of landlord if it is a Related Party.

LOANS RECEIVABLE AND INTEREST INCOME					
9. Receivable From (Indicate Related Party by Asterisk (*))	10. Date of Loan Month/Year	11. Ending Balance	12. Included At:		13. Maturity Date
			Sch. R Line	Sch. S Line	
10.					
11.					
12. TOTAL					

(Schedule I, Line 15)

Provider No.

Period Ending 1/0/1900

SCHEDULE W

ANALYSIS OF RENT EXPENSE

Part I - Noncapitalized Leases:										
1 Lessor	2 Related Organization (Yes/No)	3 Description of Property Leased	4 Total Rent Expense For Period		5 Non-Related	6 Description of Lease Terms		7 Amount Included in Rental		
			Related Party	Non-Related		From	To	Monthly Payments	Maintenance	Insurance
1.										
2.										
3.										
4.										
5.										
6. TOTAL										

(Schedule H, (Schedule H, Line 12 or 13) Line 12 or 13)

Part II - Capitalized Leases: (Schedules T & U, Line 11)										
1 Lessor	2 Related Organization (Yes/No)	3 Description of Property Leased	4 Total Rent Expense For Period		5 Non-Related	6 Description of Lease Terms		7 Amount Included in Rental		
			Related Party	Non-Related		From	To	Monthly Payments	Maintenance	Insurance
7.										
8.										
9.										
10.										
11.										
12. TOTAL										

Attach copy of lease in first year of lease and year of any change thereto.

SCHEDULE X

PATIENT TRUST FUNDS

THE FOLLOWING INFORMATION IS AS OF

[REDACTED]

1. Cash on Hand	[REDACTED]
2. Cash in Checking Account	[REDACTED]
3. Savings Accounts	[REDACTED]
4. Other (Specify)	[REDACTED]
5.	[REDACTED]
6.	[REDACTED]
7. TOTAL PATIENT TRUST FUNDS ASSETS	[REDACTED]

8. Liabilities (Attach Details)	[REDACTED]
9. Fund Balance (Should equal Line 11 below)	[REDACTED]
10. TOTAL PATIENT TRUST FUND LIABILITIES	[REDACTED]

THIS INFORMATION IS FOR THE DEPARTMENT'S USE IN CONNECTION
 WITH THE PROVISION OF COMAR 10.09.11 AND CFR 447.294(b)(5)

11. Total Balance Per Detailed Patient Ledgers	[REDACTED]
--	------------

12. Date of Last Reconciliation [REDACTED]

13. The above funds [REDACTED] (are/are not) included on the nursing home financial statements.

SCHEDULE Z

QUESTIONNAIRE AND CHECKLIST

(TO BE FILED AS A PART OF THE UNIFORM COST REPORT)

Note that an explanation must be provided for any "No" answers - see space provided at the end of the checklist. The designation N/A should be utilized if the question is not applicable.

Index

1. All requested information has been completed and is accurate and legible.

YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Schedule A

2. The certification by the owner and an officer of the Provider has been signed and the preparer, if applicable, has been listed.

YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Page 3

3. Inpatient days and occupancy data have been accurately compiled from the census records of the facility, and include hospital and leave days reimbursed.

YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. The number of beds by type agree with that certified by the Licensure Unit of DHMH.

YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Do the per diem rates in effect during the year times the applicable patient days approximate total gross revenues reported on Schedule B?

YES	NO	N/A
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provide a summary of the calculation below:

Period of Time	Per Diem Rate	Applicable Patient Days	Revenue

(Page 3) (Approximates Sch. B, Line 16)

Schedules G and H-

6. If the following line items have been completed, the supporting schedule, as indicated, has been completed:

Schedule	Lines	Supporting Schedule	YES	NO	N/A
G	1	K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	5	M	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	39	T + U	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G	40	V	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	1 - 2	V	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	10 - 11 & 14	T + U	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H	12 - 13	W	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCHEDULE Z

<u>Schedule N</u>	<u>YES</u>	<u>NO</u>	<u>N/A</u>
7. Indirect expenses included in patient care cost centers related to non-patient care activities, if any, have been calculated herein and appropriate adjustments reflected on Schedule N.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Schedule O</u>			
8. A very careful review of all transactions has been made to determine if any qualify as related party, as explained in the instructions to Schedule O, and all such transactions have been included on Schedule O.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Schedule P or Q</u>			
9. The beginning equity balances agree with the ending balances shown in the prior year's cost report; the ending equity balances agree with Schedule R or S, and net income (loss) agrees with Schedule A, Line 17, Column 2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Schedule R or S</u>			
10. A detail schedule is available for the following Balance Sheet items:			
All bank account reconciliations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient trust fund asset accounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accounts receivable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detailed fixed asset depreciation schedules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additions/retirements of property	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accounts payable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Notes payable	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prepaid and deferred amounts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accrued liabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Answer the following concerning certain Balance Sheet items (attach a separate sheet if necessary). Are any of the following owned?			
A. Airplane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Recreational Vehicle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Boat, Yacht, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Recreational facility (pool, tennis court, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the answer to any of the above is yes, provide a detail listing for each applicable asset indicating description of use, who uses, and amount of expense relating to personal use.			
<u>Schedule T</u>			
12. A review has been made to determine if there are any assets not related to patient care activities; such assets have been properly included on Lines 13 - 15.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Schedule X</u>			
13. Does the amount of Patient Trust Funds reported on Line 9 of Schedule X agree with the assets available for these patients and the detail trial balance of patient accounts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has all interest earned on patient funds been distributed to the patients or held for distribution to them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SCHEDULE Z

General

	<u>YES</u>	<u>NO</u>	<u>N/A</u>
15. The cost report has been reviewed on an overall basis for reasonableness and there has been a test of clerical accuracy performed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. There have been no changes in accounting procedures as compared to the previous period.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Is any non-patient care and/or personal use cost included in Column 3 of Schedules D, E, F and G for the following?			
A. Vehicles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Telephone cost	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Travel and entertainment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, explain in attached exhibit.			
18. Does Column 3 of Schedules D, E, F and G contain any payroll or other costs for non-patient care or personal use? If yes, explain in attached exhibit.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS ON "NO" ANSWERS

(Exclude 17 and 18 above, which require comments for "Yes" answers)

<u>Question No.</u>	<u>Comments</u>

(ATTACH ADDITIONAL SHEETS IF NECESSARY)

19. The following non-recurring expenses are included in the cost report:

<u>Amount</u>	<u>Schedule/Line</u>	<u>Description</u>