

ANALYSIS OF PROPERTY, PLANT, AND EQUIPMENT

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

ACCOUNT	Date Acquired (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Cost at End of Period (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (6)	Depreciation This Period (7)
1. Land							
2. Land Improvements							
3. Buildings							
4. Leasehold Improvements							
5. Equipment							
6. Transportation							
7. Financing Costs							
8. TOTAL*							

Has there been any change in the original historical cost of capital assets?  Yes  No If yes, submit complete detail.  
Complete for renovations in use during cost report year reimbursable under Ohio Administrative Code Rule 5101:3-3-22.

ACCOUNT - RENOVATIONS								
Year renovation completed (1)	Cost at Beginning of Period (2)	Additions or Reductions (3)	Project Cost End of Period (4)	Accumulated Depreciation End of Period (5)	Net Book Value End of Period (6)	Depreciation this Period (7)	Interest this Period (8)	Total Columns 7 and 8 (9)**
1981								
1982								
1983								
1984								
1985								
1986								
1987								
1988								
1989								
1990								
1991								
1992								
TOTAL*								

\*Totals of columns 2, 4, and 5 transfer to Schedule E.

\*\*Transfer TOTAL of column 9 to the appropriate year on Schedule D, column 3, from line 11 through line 22.

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 12-1-92

BALANCE SHEET

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

ASSETS AND LIABILITIES		Chart of Account	BALANCE PER BOOKS	
			Beginning of Period	End of Period
<b>CURRENT ASSETS</b>				
1.	Petty Cash	1001		
2.	Cash in Banks - General Account	1010		
3.	Accounts Receivable	1030		
4.	Allowance for Uncollectible Accounts	1040	( )	( )
5.	Notes Receivable	1050		
6.	Allowance for Uncollectible Notes	1060	( )	( )
7.	Other Receivables	1070		
8.	Cost Settlements	1080		
9.	Inventory	1090		
10.	Prepaid Expenses	1100		
11.	Short-Term Investments	1110		
12.	Special Investments	1120		
13.	Total Current (sum of lines 1 through 12)			
<b>PROPERTY, PLANT, AND EQUIPMENT</b>				
14.	Property, Plant and Equipment	1200		
15.	Accumulated Depreciation and Amortization	1250	( )	( )
	Renovations	1240		
	Accumulated Depreciation and Amortization - Renovations	1290	( )	( )
	Total Property, Plant, & Equipment (sum of lines 14 through 17)			
<b>OTHER ASSETS</b>				
19.	Non-Current Investments	1401		
20.	Deposits	1410		
21.	Due from Owners/Officers	1420		
22.	Deferred Charges and Other Assets	1430		
23.	Notes Receivable - Long-Term	1440		
24.	Total Other Assets (sum of lines 19 through 23)			
25.	Total Asset (sum of lines 13, 18, and 24)			
<b>CURRENT LIABILITIES</b>				
26.	Accounts Payable:	2010		
27.	Cost Settlements	2020		
28.	Notes Payable	2030		
29.	Current Portion of Long-Term Debt	2040		
30.	Accrued Compensation	2050		
31.	Payroll Related Liabilities	2060		
32.	Taxes Payable	2070		
33.	Other Liabilities, specify:	2080		
34.	Total Current Liabilities (sum of lines 26 through 33)			
<b>LONG-TERM LIABILITIES</b>				
35.	Long-Term Debt	2410		
36.	Interest Bearing Loans from Owners:	2420		
37.	Non-Interest Bearing Loans from Owners	2430		
38.	Deferred Liabilities	2450		
39.	Total Long-Term Liabilities (sum of lines 35 through 38)			
	Total Liabilities (sum of lines 34 and 39)			
	Capital - Net Worth	3000		
	Total Liabilities and Capital (must equal line 25)			

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 2-1-92

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

REIMBURSABLE EQUITY		BALANCE PER BOOKS	
		Beginning of Period (1)	End of Period (2)
CURRENT ASSETS			
1.	Capital - Net Worth		
2.	Non-Interest Bearing Loans from Owners		
3.	Equity in Assets Leased from Related Organization		
4.	Home Office Equity		
5.	Cash Surrender Value	(                    )	(                    )
6.	Other, Specify:		
7.	Other, Specify:		
8.	Other, Specify:		
9.	Other, Specify:		
10.	Other, Specify:		
11.	Other, Specify:		
12.	Other, Specify:		
13.	Other, Specify:		
14.	Other, Specify:		
15.	Other, Specify:		
16.	Total Reimbursable Equity		

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 12-1-92

RETURN ON EQUITY CAPITAL OF PROPRIETARY PROVIDERS

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

Month	Equity Beginning of Period	Capital Investments During Period	Gain or Loss Sale of Assets	Withdrawals or Dividend Distribution	Other Increase/ (Decrease)	Increases or (decrease) Due Operations	Equity Capital End of Month (net total of columns 2-7)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
17. July							
18. August							
19. September							
20. October							
21. November							
22. December							
23. Total							
24. Return on Equity		1	2	3*	4	5**	
		_____ /	_____ X	.0553125 /	_____ =	_____	(Ref. Sch. A-3, line 27)

\* Estimate Only

\*\* Maximum Return on Equity is \$1.00 (see instructions)

**INSTRUCTIONS FOR COMPLETING LINE NUMBER 24**

Column #1 Enter amount from Schedule E-1 line 23 column 8.

Column #2 Enter number of months in reporting period.

Column #4 Enter allowable property ownership days from Schedule A line 6.2.

Column #5 Enter result of the previous calculations or \$1.00 whichever is less.

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 12-1-92

CERTIFICATION BY OFFICER OF FACILITY

In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18, all cost reports submitted to ODHS will be certified as follows:

Misrepresentation or falsification of any information contained in this cost report may be punished 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 and attachments prepared for (name of provider) \_\_\_\_\_, number \_\_\_\_\_ 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.

Signature of Owner, Officer, or Authorized Representative of Provider(s)	Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider(s)	

Report Prepared by (Name)	Title
Address	
Telephone Number for Person Preparing Cost Report	Telephone Number for Facility Submitting Cost Report
Location of Records or Probable Audit Site Address	Telephone Number for Audit Contact Person

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this \_\_\_\_\_ day of \_\_\_\_\_ 19\_\_\_\_ at \_\_\_\_\_, county of \_\_\_\_\_, and state of \_\_\_\_\_.

Signature of Notary

TNS # 92-24 APPROVAL DATE 3-19-93  
SUPERSEDES  
TNS # 92-06 EFFECTIVE DATE 12-1-92

REVENUE TRIAL BALANCE

Name of Facility		Medicaid Provider Number				Reporting Period	
						From:	Through:
Revenue Account Name	Chart of Account	Total	Adjustments Increase (Decrease)	Adjusted Total			
	(1)	(2)	(3)	(4)			
<b>ROUTINE SERVICE INCOME</b>							
1. Private - Room and Board Revenue	5010						
2. Medicare - Room and Board Revenue	5020						
3. Medicaid - Room and Board Revenue	5030						
4. Veterans and other - Room and Board Revenue	5040						
5. Physical Therapy Revenue	5050						
6. Occupational Therapy Revenue	5060						
7. Speech Therapy Revenue	5070						
8. Medical Supplies - Medicare Ancillary Charges	5080						
9. Enteral Feeding Revenue	5090						
10. Other, Specify:	5095						
11. Medical Supplies - Other	5100						
12. Habilitation Supplies Revenue	5110						
13. Incontinence Supply Revenue	5120						
14. Personal Care Revenue	5130						
15. Laundry Service Revenue	5140						
16. Other Routine Service Revenue, Specify:	5150						
17. SUBTOTAL (lines 1 through 16)							
<b>OTHER OPERATING REVENUE</b>							
18. Telephone and Telegraph	5310						
19. Meals - Revenue	5320						
20. Management Services	5330						
21. Cash Discounts	5340						
22. Rebates and Refunds	5350						
23. Transfers from Restricted Funds	5360						
24. Other, Specify:							
25. SUBTOTAL (lines 18 through 24)							
<b>DEDUCTION FROM REVENUE</b>							
26. Contractual Allowance - Medicare	5510						
27. Contractual Allowance - Medicaid	5520						
28. Contractual Allowance - Other	5530						
29. Charity Allowance	5540						
30. SUBTOTAL (lines 26 through 29)							
<b>OTHER SERVICES, SPECIFY:</b>							
31. Barber and Beauty	5710						
32. Gift Shop	5720						
33. Vending Machines	5730						
34. Rental - Space	5740						
35. Rental - Equipment	5750						
36. Rental - Other	5760						
37. Interest Income - Working Capital	5770						
38. Interest Income - Restricted Funds	5780						
39. Interest Income - Funded Depreciation	5790						
40. Personal Purchases - Patients	5800						
41. Gain/Loss on Disposal of Assets	5810						
42. Radiology	5820						
43. Laboratory	5830						
44. Oxygen	5840						
45. Legend Drugs	5850						
Nurse Aide Training Program Revenue	5860						
Other Specify:							
48. SUBTOTAL (lines 31 through 47)							
49. TOTAL (sum of lines 17, 25, 30, and 48)							

TNS # 1231 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 1206 EFFECTIVE DATE 12-1-92

ADJUSTMENT TO TRIAL BALANCE

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

Description	Chart of Account	Salary Increase (Decrease)	Other Increase (Decrease)	Total Increase (Decrease)	Expenses Reference Schedule, Line	Revenue Reference Attachment 1 Line
	(1)	(2)	(3)	(4)	(5)	(6)
1. Meals - Revenue	5320				B,8	19
2. Discount, Rebates and Refunds	5340, 5350					21,22
3. Vending Machines	5730					33
4. Telephone and Telegraph	5310				C, 6	18
5. Beauty and Barber	5710					31
6. Gift Shop	5720					32
7. Rental - Space	5240					34
8. Rental - Equipment	5750				D,7	35
Rental - Other	5760					36
10. Interest - Working Capital	5770				D,8 D11-022 C, 17	37
11. Miscellaneous Income, Specify:						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						
24. TOTAL						

TNS # 92-7 APPROVAL DATE 3-9-93  
**SUPERSEDES**  
TNS # 92-06 EFFECTIVE DATE 12-7-92

Please attach one copy of the following:

1. Trial balance as of December 31, 1992. (*one copy with each cost report*)
2. Complete and detailed depreciation schedules. (*one copy only*)  
(see instructions number 22)
3. Home office allocation and trial balances pursuant to HCFA-15 Chapter 21, Section 2150 through section 2153.
4. Any other document which you feel necessary to explain your cost.

TNS # 92-24 APPROVAL DATE 3-19-93  
SUPERSEDES  
TNS # 92-26 EFFECTIVE DATE 12-1-92

COST ALLOCATION - STATISTICAL BASIS

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

COST CENTERS	Housekeeping and Operation Maintenance of Plant (1)	Cost of Ownership (2)	Dietary (3)	Routine Therapy and Nursing Services (4)	Other General Service Cost Centers (5)
1. General Service Cost					
2. Radiology					
3. Laboratory					
4. Oxygen Cost					
5. Pharmacy					
6. Other					
7. SUBTOTAL Ancillary (sum of lines 2-6)					
8. Allowable Direct Cost					
Allowable Indirect Cost					
10. Subtotal Ancillary and Routine					
11. Routine Services - Non-Certified Area					
12. Other Non-Reimbursable Cost Total					
13. TOTAL (sum of lines 2 through 12)					
14. TOTAL (generated services costs to be allocated)	\$	\$	\$	\$	\$
15. Unit Cost Multiplier (line 14 divided by line 13)					

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 12-1-92

**MEDICAID COST REPORT SUPPLEMENT**  
**Cost Allocation - General Service Cost**

Name of Facility	Medicaid Provider Number	Reporting Period
		From: _____ Through: _____

COST CENTERS	Total Reclass./Adj. Expenses Before Cost Allocation (1)	Housekeeping and Operation Maintenance of Plant (2)	Cost of Ownership (3)	Dietary (4)	Routine Therapy & Nursing Services (5)	Subtotal (columns 1-5, lines 2-12) (6)	Other General Service Cost Centers (7)	Total Expenses all patient Services (cols. 6 & 7) (8)
1. General Service Cost	\$	\$	\$	\$	\$		\$	
2. Radiology						\$		\$
3. Laboratory								
4. Oxygen Cost								
5. Pharmacy								
6. Other								
7. Subtotal Ancillary								\$
8. Allowable Direct Cost								
9. Allowable Indirect Cost								
10. Subtotal Ancillary and Routine								\$
11. Routine Services - Non-Certified Area								
12. Other Non-Reimbursable Cost Total								
13. TOTAL (column 1, lines 1-12; columns 2-7, lines 2-12; column 8, lines 10-12)	\$	\$	\$	\$	\$	\$	\$	\$
14. Ratio of Allocation (line 8 or 9 divided by line 13)								

TNS # 92-24 APPROVAL DATE 3-19-93  
 SUPERSEDES  
 TNS # 92-06 EFFECTIVE DATE 12-12