Iowa Department of Human Services

FINANCIAL AND STATISTICAL REPORT

Facility Name	Federal ID Number	Vendor Number	
	City	State	Zip
Period of Report From To	Fiscal Year Ending Mo Day Year		County
Date Facility Entered Program	Date Owner Acquired Facility		

Type of Control (check only one)

GOVERNMENT
- ❑ State
- ❑ County
- ❑ Other

NONPROFIT ORGANIZATION
- ❑ Church-Operated
- ❑ Church-Related
- ❑ Other Nonprofit

PROPRIETARY
- ❑ Individual
- ❑ Partnership
- ❑ Corporation
- ❑ "S" Corporation

Accounting Basis: ❑ Accrual ❑ Modified Cash ❑ Cash

Ownership Information

Name of Owner	% of Work Week Devoted to Business	Title	Salaries and Wages	Social Security Number	% of Ownership in Home

NOTE: Attach additional schedules as necessary to complete ownership information.

Number of Medicaid Recipients at End of Period_____

Statistical Data

	# Authorized Beds Beginning Period	# Authorized Beds End of Period	Total Bed Days Reporting Period	Total Patient Days Reporting Period	Percent Occupancy Col. 4 ÷ 3	Number of Admissions	Number of Discharges
NF							
RCF							
SNF							
ICF/MR							
RCF/MR							
Total							

An opinion of a certified public accountant of the fairness of presentation of operating results or revenues and expenses (is, is not) attached. Questions concerning financial data included in this report should be directed to:

_____ Telephone ( )_____

Certification Statement

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and imprisonment under state or federal law.

I CERTIFY that I have read the above statement and that I have examined the accompanying cost report and supporting schedules. To the best of my knowledge and belief, it is a true and complete statement prepared from the records of the provider in accordance with applicable instructions. I further certify that costs have been properly allocated between or among programs and that no cost has been reported more than once as a reimbursable cost.

Signature of Officer or Administrator of Facility	Date

TN No. MS-00-10 Approval Date NOV 9 2000
Supersedes TN No. MS-99-10 Effective Date JUL 1 2000

Facility	Vendor No.
Period of Report: From	To

SCHEDULE A

REVENUES	GENERAL LEDGER	ENTER IN COLUMN 2, SCHEDULE C	
		Adjustment Amount	Line(s) #
RESIDENT REVENUE CENTERS:			
Routine daily service			
Pharmacy, drugs and medications			73
Medical supplies			68
Laboratory			75
X-Ray			74
Occupational therapy			57
Physical therapy			57
Professional care, physician			96
Beauty, barber shop			90
Personal purchases for residents			91
Activities			
OTHER REVENUE CENTERS:			
Revenue from meals sold to guest and employee			72
Rental income			
Income of telephone charges paid by residents, guests and employees			10
Purchase discounts, if recorded			
Revenues from supplies employees			
Rebates			
Religious income			
Investment income. See instructions.			85
Other			
Average Private Pay Rate			
GROSS REVENUE			
DEDUCTIONS FROM REVENUE:			
Free care and allowances			
Provision for uncollectable accounts			
TOTAL DEDUCTIONS			
NET REVENUE (1)			

(1) Net revenue amount also must be entered on Schedule F, Reconciliation of Equity.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE B

EXPENSE ADJUSTMENTS			ENTER IN COLUMN 3, SCHEDULE C	
			Adjustment Amount	Line(s) #
NONREIMBURSABLE EXPENSES:				
Provisions for income tax				92
Fees paid Board of Directors				94
Nonworking officers' salaries				95
Travel and entertainment. See instructions.				16
Donations				97
Expenses of nonparticipating facilities				
Fund-raising expenses				
Pharmacy, drugs, and medications				73
Insurance premiums on life of officer, owner				93
Other expenses not related to resident care				
EXPENSE LIMITATIONS:				
Salaries of owners and related parties. See instructions.				
Position	Paid	Allowable		
Administrator	$	$		1
Assistant administrator				2
Management fees				13
Nursing director				40
Other				
Services, facilities, supplies furnished by organizations related to the facility by common ownership or control				
	Paid	Allowable		
Rental equipment	$	$		
Services and supplies (describe)				
Rental of facility. See instructions.	(1)	(2)		
Payments				
Lessor's cost:				
Depreciation				
Interest				
Property tax				
Other				
Return on equity				
Reduction - Column 1 less than column 2				84
Advertising expense in excess of the lesser of $3,600 or an amount computed at 2% of routine daily revenue				17
Allowable depreciation from Schedule D and D-1				81
Interest expense on loans from partners, proprietors, stockholders, or organizations. See instructions.	Expense $	Allowable $		85

Facility	Vendor No.
Period of Report: From	To

SCHEDULE B

EXPENSE ADJUSTMENTS (Cont.)			ENTER IN COLUMN 3, SCHEDULE D	
			Adjustment Amount	Line(s) #
EXPENSE ADDITIONS: Compensation of nonsalaried proprietors and partners or members of religious orders	Paid	Allowable		
Administrator	$	$		1
Nursing director				40
Other				
TOTAL				

Note: Enter adjustments on Schedule C on the line for the expense center affected.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 1

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	ADMINISTRATIVE COSTS (1)				
1	Administrator wages				
2	Business office wages				
3	Employer's taxes (Admin.)				
4	Group health, life, and retirement benefits (Admin.)				
5	Worker's comp. insurance (Admin.)				
6	Employment advertising and recruitment (Admin.)				
7	Criminal record checks (Admin.)				
8	Education and training (Admin.)				
9	Supplies (Admin.)				
10	Telephone				
11	Equipment rental (Admin.)				
12	Home office costs				
13	Management fees				
14	Accounting costs, legal, and other professional fees				
	General liability insurance				
	Travel, entertainment, and auto				
17	Advertising and public relations				
18					
19	**TOTAL ADMINISTRATIVE COSTS**				
	ENVIRONMENTAL SERVICES (1)				
20	Laundry wages				
21	Housekeeping wages				
22	Maintenance wages				
23	Employer's taxes (Environ.)				
24	Group health, life, and retirement benefits (Environ.)				
25	Worker's comp. insurance (Environ.)				
26	Employment advertising and recruitment (Environ.)				
27	Criminal record checks (Environ.)				
28	Education and training (Environ.)				
29	Supplies, laundry				
30	Supplies, housekeeping				
31	Supplies, maintenance				
32	Utilities				
33	Purchased services, laundry				
34	Purchased services, housekeeping				
35	Purchased services, maintenance				
36	Equipment repairs				
37	Equipment rental (Environ.)				
	TOTAL ENVIRONMENTAL SERVICES COSTS				

Facility	Vendor No.

SCHEDULE C - PART 1 (Cont.)

ↄCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							1
							2
							3
							4
							5
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Facility	Vendor No.
Period of Report: From	To

SCHEDULE C - PART 2

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PATIENT CARE SERVICE COSTS (1)				
	Direct Patient Care Costs				
40	D.O.N wages				
41	R.N. wages				
42	L.P.N. wages				
43	C.N.A. wages				
44	Rehabilitation wages				
45	Activities wages				
46	Social service wages				
47	Employer's taxes (Dir. Health)				
48	Group health, life, and retirement benefits (Dir. Health)				
49	Worker's comp. insurance (Dir. Health)				
50	Employment advertising and recruitment (Dir. Health)				
51	Criminal record checks (Dir. Health)				
52	Education, training (Dir. Health)				
53	Certified nurse aide training				
	Contracted professional social services				
	Professional support services				
56	Contracted nursing services				
57	Contracted rehabilitation services				
58					
59	**TOTAL DIRECT PATIENT CARE COSTS**				
	Support Care Costs				
60	Medical record wages				
61	Medical director				
62	Dietary service wages				
63	Employer's taxes (Support)				
64	Group health, life, and retirement benefits (Support)				
65	Worker's comp. insurance (Support)				
66	Employment advertising and recruitment (Support)				
67	Criminal record checks (Support)				
68	Supplies, patient care services				
69	Supplies, dietary services				
70	Supplies, activities				
71	Supplies, social services				
72	Food and nutritional supplements				
73	Pharmacy services				
74	X-Ray services				
75	Laboratory				
	Professional support services				
	Equipment rental (Patient Care)				
78					
79	**TOTAL SUPPORT CARE COSTS**				
80	**TOTAL PATIENT CARE SERVICE COSTS**				

Facility	Vendor No.

SCHEDULE C - PART 2 (Cont.)

CATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							40
							41
							42
							43
							44
							45
							46
							47
							48
							49
							50
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							80

Facility	Vendor No.
d of Report: From	To

SCHEDULE C - PART 3

Line	EXPENSES	1 Expenses per General Ledger	2 Adjustment of Expenses Schedule A	3 Adjustment of Expenses Schedule B	4 Resident Expenses
	PROPERTY COSTS (1)				
81	Depreciation (2)				
82	Amortization				
83	Real estate taxes				
84	Facility lease				
85	Interest				
86	Property and casualty insurance				
87	Building and grounds repairs				
88					
89	TOTAL PROPERTY COSTS				
	OTHER COSTS				
90	Beauty and barber shops				
91	Personal purchases for residents				
92	Income taxes				
	Officer's life insurance				
	Director fees				
	Nonworking officers' salaries				
96	Professional care (Physicians)				
97	Contributions				
98					
99	TOTAL OTHER COSTS				
100	TOTAL OF ALL EXPENSES (3)				

(1) Costs allocated to certain items are limited. See the instructions for Schedule B for a list and explanation.

(2) Depreciation in Column 1 must agree with total buildings and equipment amount from Schedule D.

(3) Total expenses in Column 1 must be entered on Schedule F, Reconciliation of Equity.

Facility	Vendor No.

SCHEDULE C - PART 3 (Cont.)

ALLOCATION OF EXPENSES OF FACILITIES PROVIDING MULTILEVEL CARE

Allocation Basis	ICF	RCF	SNF	ICF/MR	RCF/MR	Total Equal Column 4	Line
							81
							82
							83
							84
							85
							86
							87
							88
							89
							90
							91
							92
							93
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							99
							100

Facility	Vendor No.
Period of Report: From	To

SCHEDULE D

DEPRECIATION AND AMORTIZATION EXPENSE	Asset Cost	Depreciation Allowable in Prior Years	Method	Annual Rate %	Recorded Depreciation Expense	Straight-Line Depreciation
EQUIPMENT:						
Building equipment (fixed)						
Departmental equipment						
Other equipment						
Office furniture and fixtures						
Motor vehicles						
TOTAL						
BUILDINGS: (1) CONSTRUCTION						
Facility						
Additions						
Other						
vements						
TOTAL						
TOTAL BUILDINGS AND EQUIPMENT (2)						

(1) The amount of construction in progress.

(2) The amount reported as straight-line depreciation must agree with Schedule C, Line 81. The Asset Cost must agree with Schedule E, Comparative Balance Sheet.

LEASEHOLD IMPROVEMENTS (3)

Description	Construction	Cost	Prior Amount	Period	Recorded	S.T. Line
TOTAL AMORTIZATION						

(3) Questions:

1. Are the lessor or lessee the same person or group of persons or controlled by the same person or group of persons? ☐ Yes ☐ No
2. Does the lease contain an option to purchase the leased property? ☐ Yes ☐ No

Facility	Vendor No.
Period of Report: From	To

SCHEDULE D-1

Has the facility changed owners since July 18, 1984?

☐ Yes. Complete this schedule.

☐ No. This schedule does not apply.

CHANGE OF OWNERSHIP	Previous Owner's Cost	New Purchases Since Change	Depreciation Allowable in Prior Years	Method	Allowable Straight-Line Depreciation
EQUIPMENT:					
Building equipment (fixed)					
Departmental equipment					
Other equipment					
Office equipment					
Motor vehicles					
Less equipment not purchased					
TOTAL					
BUILDINGS:					
Facility					
Additions					
Other					
Land improvements					
Less buildings not purchased					
TOTAL					
TOTAL BUILDINGS AND EQUIPMENT					

Facility	Vendor No.
›d of Report: From	To

SCHEDULE E

COMPARATIVE BALANCE SHEET All information to be taken from the general ledger.	Balance at End of:	
	Current Period	Prior Period
ASSETS:		
Cash		
Investments (Money Market Certificates, Certificates of Deposit, etc.)		
Receivable from residents		
Receivable from others		
Fixed Assets:		
Land		
Buildings and improvements		
Less allowance for depreciation (per books)		
Equipment (including autos)		
Less allowance for depreciation (per books)		
Other assets		
TOTAL ASSETS		
ITIES AND EQUITY:		
Accounts payable		
Accrued taxes (payroll and property)		
Other liabilities		
Notes and mortgages payable to officers, stockholders, owners, etc.		
Notes and mortgages payable to others		
TOTAL LIABILITIES		
EQUITY: (1)		
Capital stock		
Paid-in surplus		
Retained earnings		
Partners' and proprietor's capital account(s)		
Partners' and proprietor's drawing account(s)		
Equity (nonprofit organization)		
TOTAL EQUITY		
TOTAL LIABILITIES AND EQUITY		

(1) Total equity must equal the total from Schedule F, Reconciliation of Equity.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE F

RECONCILIATION OF EQUITY	Current Period
TOTAL EQUITY BEGINNING OF PERIOD	
Add:	
Net revenue from Schedule A	
Capital stock issued	
Partners' and proprietor's additional investment	
Other. Explain	
Deduct:	
Expenses per general ledger from Schedule C	
Capital stock retired	
Sub "S" corporation distribution	
Partners' and proprietor's withdrawals	
Dividends	
Other. Explain	
TOTAL EQUITY END OF PERIOD (1)	

(1) Total equity must equal the equity reported on Schedule E, Comparative Balance Sheet.

Facility	Vendor No.
Period of Report: From	To

SCHEDULE G

Do you include as costs, services, facilities or supplies furnished by a related party or organization?

☐ Yes. Complete this schedule.

☐ No. This schedule does not apply.

TRANSACTIONS WITH RELATED ORGANIZATIONS		Included in Report		
Name of Related Party or Organization	Description of Service or Supplies	Amount	Schedule	Line

Facility	Vendor No.
Period of Report: From	To

SCHEDULE H

Nursing facilities participating in the Medicaid program must complete this schedule.

Occupation or Employment Category	Entry Level Hourly Wage (1)	Average Hourly Wage (2)	Average Hours Per Patient Day (3)
Administrative and Business Office Functions			
Laundry Services			
Housekeeping Services			
Maintenance Services			
Registered Nurses			
Licensed Practical Nurses			
Certified Nurse Aides			
Certified Medication Aides			
Restorative Aides			
Activities			
Social Services			
Contracted Nursing Services (4)			
Other Care Services (5)			
Medical Records Services			
Dietary Services			
er (please list) (6)			

(1) **Entry Level Hourly Wage** For each category listed, calculate the starting hourly wage based upon the most current wages scales established as of the end of the cost reporting period. For categories that include more than one position, average the positions included in the category. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(2) **Average Hourly Wage** For each category listed, enter the average hourly wage during the cost reporting period. Calculate this amount by dividing the total wages paid by the total hours recorded. For categories that include more than one position, sum all wages for those positions and divide by all hours for those same positions to determine the average hourly wage. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(3) **Average Hours Per Patient Day** For each category listed, enter this ratio to demonstrate staffing patterns during the cost reporting period. Calculate this amount by dividing the total hours recorded by the patient days in the period. For categories that include more than one position, sum all recorded hours and divide by the patient days. The basis for these calculations should remain consistent between periods. If you have changed the basis for these calculations between periods, send a brief explanation for the change with this form.

(4) **Contracted Nursing Services** Include calculations derived from invoices submitted by outside or temporary staffing agencies. Combine all nursing employment categories covered on these invoices, including RNs, LPNs, CNAs, etc.

(5) **Other Care Services** If you have other categories of employees that don't directly correlate to one of the categories listed, enter them on this line if the position is related to your patient or health care services. Examples include chaplain, religious services, bed-maker, etc.

Other If you have any other categories of employees or contracted workers that don't directly correlate to one of the categories listed, complete this line. Note that contracted therapy services or therapy department employees are specifically excluded from this report.