

**IOWA DEPARTMENT OF HUMAN SERVICES  
FINANCIAL AND STATISTICAL REPORT**

Facility Name - (as appears on License)				Federal ID Number																						
				Medicare Number																						
Physical Address (Required)																										
Street		City		State	Zip																					
Period of Report				County																						
From:		To:																								
Did a change in ownership occur on the first date of this cost report period					FYE (mm/dd)																					
Yes		No																								
If change in ownership, is this cost report:																										
Initial		Rate Setting		First Annual																						
Type of Control (Check Only One)																										
GOVERNMENT		NON-PROFIT ORGANIZATION		PROPRIETARY																						
<input type="checkbox"/> State		<input type="checkbox"/> Church Operated		<input type="checkbox"/> Individual																						
<input type="checkbox"/> County		<input type="checkbox"/> Church Owned		<input type="checkbox"/> Partnership / LLP / LP																						
<input type="checkbox"/> Other Non-State Government		<input type="checkbox"/> Other Non-Profit		<input type="checkbox"/> Corporation																						
				<input type="checkbox"/> LLC / LC																						
				<input type="checkbox"/> "S" Corporation																						
				<input type="checkbox"/> Other For-Profit																						
<table border="1"> <thead> <tr> <th>No.</th> <th>Program Type</th> <th>National Provider Identifier</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Nursing Facility</td> <td></td> </tr> <tr> <td>2</td> <td>Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID)</td> <td></td> </tr> <tr> <td>3</td> <td>Intermediate Care Facility for the Medically Complex (ICF/MC)</td> <td></td> </tr> <tr> <td>4</td> <td>Assisted Living</td> <td></td> </tr> <tr> <td>5</td> <td>Independent Living</td> <td></td> </tr> <tr> <td>6</td> <td>Other</td> <td></td> </tr> </tbody> </table>						No.	Program Type	National Provider Identifier	1	Nursing Facility		2	Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID)		3	Intermediate Care Facility for the Medically Complex (ICF/MC)		4	Assisted Living		5	Independent Living		6	Other	
No.	Program Type	National Provider Identifier																								
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4	Assisted Living																									
5	Independent Living																									
6	Other																									
<b>Notice</b>																										
Any person that knowingly submits false, misleading, or incomplete information, responses, or representations may be subject to criminal, civil, or administrative liability.																										
<b>Certification of Officer or Administrator of Facility</b>																										
Officer or Administrator of Facility certifies that I have read the above Notice, the Certification of the Preparer, and the accompanying cost report and supporting schedules. I certify as to all the statements certified by the preparer. I further certify that to the best of my knowledge and belief the information taken from the records of the provider is true, accurate, complete and verifiable.																										
Name of Officer or Administrator of Facility				Date																						
Title / Position				Telephone																						
Signature of Officer or Administrator of Facility																										
<b>Certification of Preparer</b>																										
Preparer certifies that they have read the above Notice and inspected the accompanying cost report and supporting schedules and that to the best of their knowledge and belief: (1) it is a true and complete statement prepared from the records of the provider;(2) the applicable instructions and guidance in preparing the cost report has been followed; (3) costs have been properly allocated between or among programs and no cost has been reported more than once as a reimbursable cost; and (4) no presumptively allowable cost is included as an allowable cost unless the cost is separately and specifically identified as a presumptively unallowable cost.																										
Name of Preparer				Date																						
Preparer Company Name				Telephone																						
Signature of Preparer																										
In addition to the Officer or Administrator of Facility, correspondence concerning the cost report should be directed to:																										
Name:				Telephone																						
Company Name:				Email:																						
Address:																										

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	NPI:	
Period of Report: From	01/00/00	To:	01/00/00

Provider Identification

Provider Name	National Provider Identification	Provider Tax Identification (TIN)	Program Type	Address	Relation
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**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	0	<b>NPI:</b>	
<b>Period of Report:</b> <b>From</b>	01/00/00	<b>To:</b>	01/00/00

<b>Provider Identification</b>
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Provider Name	National Provider Identification	Provider Tax Identification (TIN)	Program Type	Address	Relation
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**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>		<b>NPI:</b>	
<b>Period of Report:</b>	<b>From:</b>	<b>To:</b>	

Identify which managed care organizations you have contracts with:			
		Yes	No
		Yes	No
		Yes	No
		Yes	No

Does this facility have a Licensed CCDI Unit?	Yes	No	Date Licensed:	
			Certification No.:	

Is this facility a CCRC?	Yes	No	Date Certified:	
			Certification No.:	

Accounting Basis	Accrual	Modified	Cash
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Does this facility have annual financials prepared by an outside firm?	Yes	No	Description:	
Type	Compilation Audit	Review Other		
Are notes to financial statements (FS) included?	Yes	No		
Is the FS on the same period as cost report?	Yes	No		
Has the FS been issued?	Yes	No		
If "NO", please indicate the estimated date of issuance.			Date Expected:	
If "YES", include a copy of the report, opinion, statements and notes as appropriate				

Do you have a home office that provides administrative support?	Yes	No
Name:		Medicare ID:
Which line of Schedule D are the costs reported?		
Are the costs disclosed on Schedule G	Yes	No
If there is a home office, provide a cost statement for the home office, including allocations		

Do you have a management company?	Yes	No
Name:		
Is the management company a related entity?	Yes	No
If related, are the costs disclosed on Schedule G?	Yes	No
Has the current agreement been previously submitted?	Yes	No
Has there been any significant changes in the terms of the contract?	Yes	No
If, the current management agreement has not been submitted, or there have been significant changes provide a copy as appropriate.		

Are there related party salaries reported on the cost report?	Yes	No
Did you use related party vendors during the year?	Yes	No
Are related party salaries and vendor payments reported on Schedule G?	Yes	No

Has the facility changed owners since 6/18/84?	Yes	No	Date of change:	
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What depreciation method is used for book purposes?	GAAP	Tax
	Straight Line	Other
Have adjustments been made to report straight line on the cost report?	Yes	No

Has any allocation method changed from prior year?	Yes	No
If Yes, please identify which lines are affected		

Is the facility self-insured?	Yes	No
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Who is the Medical Director?	
Are they compensated?	Yes
Amount	

Are you claiming any legal fees associated with an administrative or judicial proceeding?	Yes	No
Have all requirements of IAC 441 Chapter 81.6(11)o, 82.5(11)m or 54.3(11)n been met?	Yes	No

\* If yes, please include a copy of the complaint, dispositive motions and orders, judgment, invoices, periods that costs were incurred, periods that costs were paid and a summary of hours and hourly rates paid. Also include documentation detailing good-faith efforts to settle the dispute.

Do agreements with residents require arbitration?	Yes	No
Are costs related to arbitration reported on Schedule D?	Yes	No
Which line of Schedule D are the costs reported?		

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	<b>From:</b>	<b>NPI:</b>	
<b>Period of Report:</b>		<b>To:</b>	

**Statistical Data**

Line No.	Type of Facility	# Authorized Beds		Total Bed Days in Reporting Period (3)	Resident Days in Reporting Period										
		Start of Period (1)	End of Period (2)		Total (4)	Medicaid (5)	Medicaid Managed Care (6)	Medicare Part A and Managed Care (7)	Private Pay / Insurance (8)	Non-Medicaid Hospice (9)	Medicaid Hospice (10)	Veterans Affairs (11)	State Supplemental Assistance (11)	County (12)	Other (13)
1	Nursing Facility														
2	ICF/ID														
3	ICF/MC														
4	Assisted Living														
5	Independent Living														
6	Other														
7	<b>TOTAL</b>														

Line No.	Type of Facility	Medicaid Utilization Col 5&6 / 4 (14)	Percent Occupancy Col 4/3 (15)	Number of Unduplicated Admissions (16)	Number of Unduplicated Discharges (17)	Paid Bed Hold Days (18)	Non-Paid Bed Hold Days (19)
1	Nursing Facility						
2	ICF/ID						
3	ICF/MC						
4	Assisted Living						
5	Independent Living						
6	Other						
7	<b>TOTAL</b>						

MCO 1 (20)	MCO 2 (21)	MCO 3 (22)	MCO 4 (23)



IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name: \_\_\_\_\_  
 Period of Report: From: \_\_\_\_\_

NPI: \_\_\_\_\_  
 To: \_\_\_\_\_

SCHEDULE A TOTAL FACILITY REVENUE

Personal purchases for residents	225	\$	-																
Activities	226	\$	-																
Other Ancillary	227	\$	-																
<b>OTHER REVENUE CENTERS:</b>																			
Meals sold to guest & employee	228	\$	-																
Income from private room	229	\$	-																
Rental Income	230	\$	-																
Income of telephone / cable / technology charges paid by residents, guests, and employees	231	\$	-																
Purchase discounts, if recorded	232	\$	-																
Revenues from supplies employees	233	\$	-																
Rebates	234	\$	-																
Religious Income	235	\$	-																
Realized Investment Income	236	\$	-																
Unrealized Investment Income	237	\$	-																
Work services revenue / member wages	238	\$	-																
Personal use of vehicles	239	\$	-																
Unrestricted Contributions	240	\$	-																
Restricted Contributions	241	\$	-																
Donations	242	\$	-																
Grants	243	\$	-																
Gain / Loss on sale of asset	244	\$	-																
Insurance Settlement	245	\$	-																
Other	246	\$	-																
<b>GROSS REVENUE</b>	<b>247</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>
<b>DEDUCTIONS FROM REVENUE:</b>																			
Contractual Allowances	248	\$	-																
Provision for uncollectible accounts	249	\$	-																
<b>TOTAL DEDUCTIONS</b>	<b>250</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>
<b>NET REVENUE</b>	<b>251</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>	<b>\$</b>	<b>-</b>

AVERAGE PRIVATE PAY RATE \_\_\_\_\_ Description of calculation of average private pay rate: \_\_\_\_\_

\_\_\_\_\_

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	
<b>Period of Report:</b>	<b>From:</b>

<b>NPI:</b>	
<b>To:</b>	

**SCHEDULE B EXPENSE ADJUSTMENTS**

Description	Line No.	IAC 441 Chapter(s)	Expenses per General Ledger (1)	Allowable (2)	COL. 3 SCHEDULE D		Amount of Adjustment to:						
					Adjustment amount (3)	Line(s) # (4)	Allocation Basis (5)	NF (6)	ICF/ID (7)	ICF/MC (8)	Assisted Living (9)	Independent Living (10)	Other (11)
<b>NONREIMBURSABLE:</b>													
Provisions for income tax	411	81.6(11)a, 82.5(11)a			\$ -								
Fees paid Board of Directors	412	81.6(11)b, 82.5(11)b			\$ -								
Non-Working officer's salaries	413	81.6(11)b, 82.5(11)c			\$ -								
Bad Debts	414	81.6(11)c			\$ -								
Donations	415	81.6(11)d			\$ -								
Expenses of non-participating facilities	416	CMS 15-1 § 2102.3			\$ -								
Other expenses not related to resident care	417	CMS 15-1 § 2102.3			\$ -								
Fund-raising expenses	418	CMS 15-1 § 2136.2			\$ -								
Pharmacy, drugs, and medications	419	81.6(11)q			\$ -								
Laboratory	420	81.6(10)a			\$ -								
X-ray	421	81.6(10)a			\$ -								
Insurance premiums on life of officer / owner	422	CMS 15-1 § 2130			\$ -								
Lobbying fees	423	81.6(11)o, 82.5(11)m			\$ -								
Assessment fees	424	81.6(11)p, 82.5(13)			\$ -								
Penalties, Fines, NSF Fees, Delinquent Payment Fees	425	81.6(11)s, 81.6(11)t, 82.5(11)n, 82.5(11)o			\$ -								
<b>LIMITED EXPENSES:</b>													
Travel & Entertainment (NF)	426	81.6(11)e			\$ -								
Administrative costs (ICF/ID, ICF/MC)	427	82.5(16)e			\$ -								
Related Party Compensation (wages, salaries, benefits, and payroll taxes) - Schedule G	428	81.6(11)h, 81.2(11)e			\$ -								
Related Party Payments - Schedule G	429	81.6(11)k, 81.6(11)l, 81.6(11)m, 82.5(11)f, 82.5(11)h, 82.5(11)i, 82.5(11)j			\$ -								
Straight-line depreciation	430	81.6(11)j, 82.6(11)g			\$ -								



**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	
<b>Period of Report:</b>	<b>From:</b>

<b>NPI:</b>	
<b>To:</b>	

**SCHEDULE B EXPENSE ADJUSTMENTS**

Description	Line No.	IAC 441 Chapter(s)	Expenses per General Ledger (1)	Allowable (2)	COL. 3 SCHEDULE D			Amount of Adjustment to:						
					Adjustment amount (3)	Line(s) # (4)	Allocation Basis (5)	NF (6)	ICF/ID (7)	ICF/MC (8)	Assisted Living (9)	Independent Living (10)	Other (11)	
Allowable Depreciation - Schedule C, C-1 and G-2	431	81.6(12)b, 82.5(12)b			\$ -									
Promotional advertising expense in excess of the lesser of \$7,200 or an amount computed at 2% of daily revenue	432	Instructions			\$ -									
Legal Fees	433	81.6(11)o, 82.5(11)m			\$ -									
Occupational Therapy	434	81.6(11)r			\$ -									
Physical Therapy	435	81.6(11)r			\$ -									
Speech Therapy	436	81.6(11)r			\$ -									
Respiratory Therapy	437	81.6(11)r			\$ -									
<b>TOTAL</b>	<b>438</b>				<b>\$ -</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**NOTE:** Enter adjustments on Schedule D on the line for the expense center affected.

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>		<b>NPI:</b>	
<b>Period of Report: From</b>		<b>To:</b>	

SCHEDULE C Depreciation									
Description	Line No.	Construction in Process(1)	Beginning Historical Basis Asset Cost (2)	Purchases during period (3)	Disposals during period (4)	Ending Historical Basis (5)	Accumulated Straight Line Depreciation Allowable Reported in Prior Years (6)	Straight Line Useful Life (7)	Straight Line Depreciation (8)
<b>EQUIPMENT:</b>									
Building Equipment (fixed)	750					\$ -			
Department Equipment	751					\$ -			
Other Equipment	752					\$ -			
Office Furniture & Fixtures	753					\$ -			
<b>Subtotal Equipment</b>	754	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -
Motor Vehicles	755								
<b>TOTAL EQUIPMENT</b>	756	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -
<b>BUILDINGS:</b>									
Facility	760					\$ -			
Other	761					\$ -			
Leasehold Improvements	762					\$ -			
Land Improvements	763					\$ -			
Right to use assets	764					\$ -			
<b>TOTAL BUILDINGS</b>	765	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -
<b>AMORTIZATION (PLEASE ATTACH SCHEDULE D)</b>	770								
<b>TOTAL DEPRECIATION AND AMORTIZATION</b>	780	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -		\$ -

SCHEDULE C Depreciation								
Description	Line No.	Straight Line Depreciation (8)	Allocation Basis (9)	NF (10)	ICF/ID (11)	Assisted Living (12)	Independent Living (13)	Other (14)
<b>EQUIPMENT:</b>								
Building Equipment (fixed)	750							

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>						<b>NPI:</b>			
<b>Period of Report: From</b>						<b>To:</b>			
Department Equipment	751								
Other Equipment	752								
Office Furniture & Fixtures	753								
<b>Subtotal Equipment</b>	754			\$ -	\$ -	\$ -	\$ -		
Motor Vehicles	755								
<b>TOTAL EQUIPMENT</b>	756			\$ -	\$ -	\$ -	\$ -		
<b>BUILDINGS:</b>									
Facility	760								
Other	761								
Leasehold Improvements	762								
Land Improvements	763								
Right to use assets	764								
<b>TOTAL BUILDINGS</b>	765			\$ -	\$ -	\$ -	\$ -		
<b>AMORTIZATION (PLEASE ATTACH SCHEDULE C)</b>									
	770								
<b>TOTAL DEPRECIATION AND AMORTIZATION</b>									
	780			\$ -	\$ -	\$ -	\$ -		

SCHEDULE C Depreciation					
Description	Line No.	Book Method (15)	Book Annual Rate % (16)	Book Depreciation Expense (17)	Accumulated Book Depreciation End of Period (18)
<b>EQUIPMENT:</b>					
Building Equipment (fixed)	750				
Department Equipment	751				
Other Equipment	752				
Office Furniture & Fixtures	753				
<b>Subtotal Equipment</b>	754			\$ -	\$ -
Motor Vehicles	755				
<b>TOTAL EQUIPMENT</b>	756			\$ -	\$ -
<b>BUILDINGS:</b>					

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>						<b>NPI:</b>			
<b>Period of Report: From</b>						<b>To:</b>			
Facility	760								
Other	761								
Leasehold Improvements	762								
Land Improvements	763								
Right to use assets	764								
<b>TOTAL BUILDINGS</b>	765				\$ -	\$ -			
<b>AMORTIZATION (PLEASE ATTACH SCHEDUL</b>	770								
<b>TOTAL DEPRECIATION AND AMORTIZATION</b>	780				\$ -	\$ -			

IOWA FINANCIAL AND STATISTICAL REPORT

<b>Facility Name:</b>
<b>Period of Report: From</b>

<b>NPI:</b>
<b>To:</b>

**SCHEDULE C-1  
CHANGE OF OWNERSHIP**

	Line No.	Previous Owner's Cost (1)	Purchases since Change in Ownership (2)	Depreciation Allowable in Prior Years (3)	Allowable Straight-Line Depreciation (4)
<b>EQUIPMENT:</b>					
Building equipment (fixed)	781				
Department equipment	782				
Other equipment	783				
Office furniture & fixtures	784				
Motor vehicles	785				
	786				
Less equipment not purchased	787				
<b>TOTAL</b>	788	\$ -	\$ -	\$ -	\$ -
<b>BUILDINGS:</b>					
Facility	789				
Additions	790				
Other	791				
	792				
Land Improvements	793				
	794				
Less buildings not purchased	795				
<b>TOTAL</b>	796	\$ -	\$ -	\$ -	\$ -
<b>TOTAL BUILDINGS AND EQUIPMENT</b>	797	\$ -	\$ -	\$ -	\$ -

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	NPI:
Period of Report: From:	01/00/00	To: 01/00/00

SCHEDULE D SCHEDULE OF EXPENSES

	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses Sch A Sch. B		Resident Expenses (4)	Allocation Basis (5)	NF (6)	ICF/ID (7)	ICF/MC (8)	Assisted Living (9)	Ind. Living (10)	Other (11)	Total Equals Column 4 (12)
			(2)	(3)									
Administrator wages	1				\$ -								\$ -
Business office wages	2				\$ -								\$ -
Advertising & marketing wages	3				\$ -								\$ -
Employer's taxes (Admin)	4				\$ -								\$ -
Group / Life & Retirement Benefits (Admin)	5				\$ -								\$ -
Worker's comp. insurance (Admin.)	6				\$ -								\$ -
Employment Advertising & Recruit (Admin.)	7				\$ -								\$ -
Criminal record checks (Admin.)	8				\$ -								\$ -
Education & training (Admin.)	9				\$ -								\$ -
Supplies (Admin.)	10				\$ -								\$ -
Telephone	11				\$ -								\$ -
Equipment rental (Admin.)	12				\$ -								\$ -
Home office costs	13				\$ -								\$ -
Management fees	14				\$ -								\$ -
Accounting	15				\$ -								\$ -
Professional organization dues	16				\$ -								\$ -
Licensing fees	17				\$ -								\$ -
Information technology	18				\$ -								\$ -
Legal fees - direct patient care related	19				\$ -								\$ -
Legal fees - other	20				\$ -								\$ -
Working capital interest	21				\$ -								\$ -
General liability insurance	22				\$ -								\$ -
Travel, entertainment, & auto	23				\$ -								\$ -
Advertising & public relations	24				\$ -								\$ -
	25				\$ -								\$ -
<b>TOTAL ADMINISTRATIVE COSTS</b>	26	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Laundry wages	27				\$ -								\$ -
Housekeeping wages	28				\$ -								\$ -
Maintenance wages	29				\$ -								\$ -
Environmental Universal Worker	30				\$ -								\$ -
Employer's taxes (Enviro.)	31				\$ -								\$ -
Group / Life & Retirement Benefits (Enviro.)	32				\$ -								\$ -
Worker's comp. insurance (Enviro.)	33				\$ -								\$ -
Employment Advertising & Recruit (Enviro.)	34				\$ -								\$ -
Criminal record checks (Enviro.)	35				\$ -								\$ -
Education & training (Enviro.)	36				\$ -								\$ -
Supplies - laundry	37				\$ -								\$ -
Supplies - housekeeping	38				\$ -								\$ -
Supplies - maintenance	39				\$ -								\$ -
Utilities	40				\$ -								\$ -
Purchased services - laundry	41				\$ -								\$ -
Purchased services - housekeeping	42				\$ -								\$ -
Purchased services - maintenance	43				\$ -								\$ -
Equipment repairs	44				\$ -								\$ -
Equipment rental (Enviro.)	45				\$ -								\$ -
	46				\$ -								\$ -
<b>TOTAL ENVIRONMENTAL SERVICE COSTS</b>	47	\$ -	\$ -	\$ -	\$ 14 -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	NPI:
Period of Report: From:	01/00/00	To: 01/00/00

SCHEDULE D SCHEDULE OF EXPENSES

	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses Sch A Sch. B		Resident Expenses (4)	Allocation Basis (5)	NF (6)	ICF/ID (7)	ICF/MC (8)	Assisted Living (9)	Ind. Living (10)	Other (11)	Total Equals Column 4 (12)
			(2)	(3)									
Depreciation	48				\$ -								\$ -
Amortization	49				\$ -								\$ -
Real estate taxes	50				\$ -								\$ -
Facility lease	51				\$ -								\$ -
Property interest	52				\$ -								\$ -
Property & casualty insurance	53				\$ -								\$ -
Building & grounds repairs	54				\$ -								\$ -
	55				\$ -								\$ -
<b>TOTAL PROPERTY COSTS</b>	<b>56</b>	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL ADMINISTRATIVE, ENVIRONMENTAL &amp; PROPERTY COSTS</b>	<b>57</b>	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Director of nursing wages	58				\$ -								\$ -
Administrative nursing wages- Asst. DON, MDS Coordinator., etc	59				\$ -								\$ -
Medical record wages	60				\$ -								\$ -
Medical Director	61				\$ -								\$ -
Activities wages	62				\$ -								\$ -
Social service wages	63				\$ -								\$ -
Dietary service wages	64				\$ -								\$ -
Support Universal Worker	65				\$ -								\$ -
Employer's taxes (Support)	66				\$ -								\$ -
Group / Life & Retirement Benefits (Support)	67				\$ -								\$ -
Worker's comp. insurance (Support)	68				\$ -								\$ -
Employment Advertising & Recruit (Support)	69				\$ -								\$ -
Criminal record checks (Support)	70				\$ -								\$ -
Education & training (Support)	71				\$ -								\$ -
Routine supplies - patient care services	72				\$ -								\$ -
Non-routine supplies - patient care services	73				\$ -								\$ -
Non-routine supplies - DME	74				\$ -								\$ -
Supplies - dietary services	75				\$ -								\$ -
Supplies - activities	76				\$ -								\$ -
Supplies - social services	77				\$ -								\$ -
Supplies - therapies	78				\$ -								\$ -
Food & nutritional supplements	79				\$ -								\$ -
Pharmacy - OTC	80				\$ -								\$ -
Pharmacy - consulting	81				\$ -								\$ -
X-ray services - in-house	82				\$ -								\$ -
Laboratory - in-house	83				\$ -								\$ -
Contracted professional social services	84				\$ -								\$ -
Professional support services	85				\$ -								\$ -
Equipment rental (Support)	86				\$ -								\$ -
	87				\$ -								\$ -
<b>TOTAL SUPPORT CARE COSTS</b>	<b>88</b>	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL NON-DIRECT CARE COSTS</b>	<b>89</b>	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
RN wages	90				\$ -								\$ -
LPN wages	91				\$ -								\$ -
Certified aides - CNA, CMA, etc wages	92				\$ -								\$ -

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	0	NPI:
Period of Report: From:	01/00/00	To: 01/00/00

SCHEDULE D SCHEDULE OF EXPENSES

	Line No.	Expenses per General Ledger (1)	Adjustment of Expenses Sch A Sch. B		Resident Expenses (4)	Allocation Basis (5)	NF (6)	ICF/ID (7)	ICF/MC (8)	Assisted Living (9)	Ind. Living (10)	Other (11)	Total Equals Column 4 (12)
			(2)	(3)									
Direct Care Universal Worker	93				\$ -								\$ -
Therapy salaries - inpatient residents	94				\$ -								\$ -
Therapy salaries - outpatient care	95				\$ -								\$ -
Direct support professionals	96				\$ -								\$ -
Other direct care wages	97				\$ -								\$ -
Employer's taxes (Direct)	98				\$ -								\$ -
Group / Life & Retirement Benefits (Direct)	99				\$ -								\$ -
Worker's comp. insurance (Direct)	100				\$ -								\$ -
Employment Advertising & Recruit (Direct)	101				\$ -								\$ -
Criminal record checks (Direct)	102				\$ -								\$ -
Education & training (Direct)	103				\$ -								\$ -
Certified nursing aide training	104				\$ -								\$ -
Professional support - nurse consulting	105				\$ -								\$ -
Contracted nursing services - RN, LPN	106				\$ -								\$ -
Contracted nursing services - aides	107				\$ -								\$ -
Therapy services - inpatient residents	108				\$ -								\$ -
Therapy services - outpatient care	109				\$ -								\$ -
	110				\$ -								\$ -
<b>TOTAL DIRECT PATIENT CARE COSTS</b>	111	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Beauty & barber shops	112				\$ -								\$ -
Personal purchases for residents	113				\$ -								\$ -
Professional care - physicians	114				\$ -								\$ -
Provisions for income tax	115				\$ -								\$ -
Fees paid Board of Directors	116				\$ -								\$ -
Non-Working officer's salaries	117				\$ -								\$ -
Fundraising expenses	118				\$ -								\$ -
Bad Debts	119				\$ -								\$ -
Donations	120				\$ -								\$ -
Expenses of non-participating facilities	121				\$ -								\$ -
Pharmacy - prescription (legend)	122				\$ -								\$ -
X-ray services - referral	123				\$ -								\$ -
Laboratory - referral	124				\$ -								\$ -
Insurance premiums on life of officer / owner	125				\$ -								\$ -
Lobbying fees	126				\$ -								\$ -
Assessment fees	127				\$ -								\$ -
Penalties, Fines, NSF Fees, Delinquent Payment Fees	128				\$ -								\$ -
	129				\$ -								\$ -
<b>TOTAL OTHER COSTS</b>	130	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>TOTAL OF ALL EXPENSES</b>	131	\$ -	\$ -	\$ -	\$ -		\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -



**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	<b>NPI:</b>
<b>Period of Report: From:</b>	<b>To:</b>

**SCHEDULE E COMPARATIVE BALANCE SHEET**

All information to be taken from the general ledger.	Line No.	Balance at the End of:	
		Current Period (1)	Prior Period (2)
<b>ASSETS:</b>			
<b>CURRENT ASSETS:</b>			
Cash on hand and in banks	801		
Temporary investments	802		
Notes receivable	803		
Accounts receivable: residents	804		
Other receivables	805		
Less: Allowances for uncollectible notes and accounts receivable	806		
Inventory	807		
Prepaid expenses	808		
Other current assets	809		
Due from other funds	810		
<b>TOTAL CURRENT ASSETS</b>	<b>811</b>		
<b>FIXED ASSETS</b>			
Land	812		
Land improvements	813		
Less: Accumulated depreciation	814		
Buildings	815		
Less: Accumulated depreciation	816		
Leasehold improvements	817		
Less: Accumulated depreciation	818		
Fixed equipment	819		
Less: Accumulated depreciation	820		
Automobiles and trucks	821		
Less: Accumulated depreciation	822		
Major movable equipment	823		
Less: Accumulated depreciation	824		
Minor equipment - Depreciable	825		
Less: Accumulated depreciation	826		
Minor equipment - Non-Depreciable	827		
Construction in Process	828		
Other fixed assets	829		
<b>TOTAL FIXED ASSETS</b>	<b>830</b>		
<b>OTHER ASSETS</b>			
Investments	831		
Deposits on leases	832		
Accounts receivable: related parties	833		
Other assets	834		
<b>TOTAL OTHER ASSETS</b>	<b>835</b>		
<b>TOTAL ASSETS</b>	<b>836</b>		

**SCHEDULE E COMPARATIVE BALANCE SHEET**

All information to be taken from the general ledger.	Line No.	Balance at the End of:	
		Current Period (1)	Prior Period (2)
<b>LIABILITIES:</b>			
<b>CURRENT LIABILITIES</b>			
Accounts payable	837		
Salaries, wages, and fees payable	838		
Payroll taxes payable	839		
Notes & loans payable (short term)	840		
Deferred income	841		
Accelerated payemtns	842		
Due to other funds	843		
Other current liabilities	844		
<b>TOTAL CURRENT LIABILITIES</b>	<b>845</b>		
<b>LONG TERM LIABILITIES</b>			
Mortgage payable	846		
Notes payable	847		
Unsecured loans	848		
Other long term liabilities	849		
Other (specify)	850		
<b>TOTAL LONG TERM LIABILITIES</b>	<b>851</b>		

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	<b>NPI:</b>
<b>Period of Report: From:</b>	<b>To:</b>

<b>RELATED PARTY LIABILITIES</b>			
Accounts payable - related party	852		
Salaries, wages, and fees payable - related party	853		
Mortgage payable - related party	854		
Notes payable - related party	855		
<b>TOTAL RELATED PARTY LIABILITIES</b>	<b>856</b>		
<b>TOTAL LIABILITIES</b>	<b>857</b>		

<b>CAPITAL ACCOUNTS:</b>			
General fund balance	858		
Specific purpose fund	859		
Donor created - endowment fund balance - restricted	860		
Donor created - endowment fund balance - unrestricted	861		
Governing body created - endowment fund balance	862		
Plant fund balance - invested in plant	863		
Plant fund balance - reserve for plant inprovment, replacement	864		
<b>TOTAL FUND BALANCES</b>	<b>865</b>		
<b>TOTAL LIABILITIES AND FUND BALANCES</b>	<b>866</b>		

<b>RECONCILIATION OF EQUITY</b>		
	<b>Line No.</b>	<b>Current Period</b>
<b>TOTAL EQUITY BEGINNING OF PERIOD</b>	867	
<b>Add:</b>		
Net revenue from Schedule A	868	
Capital stock issued	869	
Partners' and proprietor's additional investment	870	
Other: Explain	871	
	872	
	873	
<b>Deduct:</b>		
Expenses per general ledger from Schedule D	874	
Capital stock retired	875	
Sub "S" corporation distribution	876	
Partners' and proprietor's withdrawals	877	
Dividends	878	
Other: Explain	879	
	880	
	881	
<b>TOTAL EQUITY END OF PERIOD</b>	<b>882</b>	

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>		<b>NPI:</b>
<b>Period of Report:</b>	<b>From:</b>	<b>To:</b>

**SCHEDULE G - OWNER DISCLOSURE AND RELATED PARTY TRANSACTIONS**

**I. SALARIES AND WAGES**

Line No.	Name of Controlling or Related Individual (1)	Social Security Number or Employer Identification Number (2)	Percent Ownership (3)	Type of Party (4)	% of Work Week Devoted to Business (5)	Total Compensation (wages, salaries, benefits, and payroll taxes) (6)	Allowable Compensation (wages, salaries, benefits, and payroll taxes) (7)	Has Cost Been Adjusted to Lower of Total or Allowable (8)	Line on Sch D on Which Compensation (wages, salaries, benefits, and payroll taxes) are Reported (9)
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

**II. SERVICES AND SUPPLIES**

Line No.	Name of Related Entity (10)	Social Security Number or Employer Identification Number (11)	Type of Service or Supply (12)	Type of Party (13)	Amount of Related Party Expense (14)	Amount Paid by Facility (15)	Has Cost Been Adjusted to Lower of column 14 or 15 (16)	Do you have an exception to provide the type of service (17)	Line on Sch D on which services or supplies are reported (18)
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									

Type of Party: 1 - Owner 2 - Board Member 3 -Related party 4 - Related vendor

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>		<b>NPI</b>	
<b>Period of Report:</b>	<b>From:</b>	<b>To:</b>	

**SCHEDULE G-1 - RELATED PARTY COMPENSATION LIMITS**

**I. Nursing Facility**

	Related Individual (1)	Related Individual (2)	Related Individual (3)	Related Individual (4)	Related Individual (5)	Related Individual (6)	Related Individual (7)	Related Individual (8)	Related Individual (9)	Related Individual (10)
<b>Job Function (Administrator / Non-Administrator)</b>										
<b>Salary</b>										
<b>Healthcare benefits / premiums</b>										
<b>Retirement benefits</b>										
<b>Life insurance</b>										
<b>Other benefits / compensation</b>										
<b>Total Compensation</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Base Allowable</b>	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33	\$ 5,038.33
<b>Per Bed over 60</b>	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75	\$ 53.75
<b>Months of Cost Report</b>	12	12	12	12	12	12	12	12	12	12
<b>Beds</b>										
<b>Maximum Base</b>	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77	\$ 7,465.77
<b>Calculated Maximum:</b>										
<b>Base</b>	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96
<b>Beds above max</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total per cost report</b>	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96
<b>Maximum Base</b>	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24	\$ 89,589.24
<b>Full Related Party Limit</b>	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96	\$ 60,459.96
<b>% of Administrator Limit</b>	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%
<b>% of time devoted</b>										
<b>Maximum Compensation</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Excess Compensation (Sch B, Line 428)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Excess payroll taxes (7.65%) (Sch B, Line 428)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Sch D Line of Salary Adjustment</b>										
<b>Sch D Line of Benefit Adjustment</b>										
<b>Sch D Line of PR taxes Adjustment</b>										

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>		<b>NPI</b>	
<b>Period of Report:</b>	<b>From:</b>	<b>To:</b>	

**SCHEDULE G-1 - RELATED PARTY COMPENSATION LIMITS**

<b>II. ICF/ID &amp; ICF/MC</b>										
	Related Individual (1)	Related Individual (2)	Related Individual (3)	Related Individual (4)	Related Individual (5)	Related Individual (6)	Related Individual (7)	Related Individual (8)	Related Individual (9)	Related Individual (10)
<b>Job Function (Administrator / Non-Administrator)</b>										
<b>Salary</b>										
<b>Healthcare benefits / premiums</b>										
<b>Retirement benefits</b>										
<b>Life insurance</b>										
<b>Other benefits / compensation</b>										
<b>Total Compensation</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Base Allowable</b>	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72	\$ 2,766.72
<b>Per Bed over 60</b>	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90	\$ 28.90
<b>Months of Cost Report</b>	12	12	12	12	12	12	12	12	12	12
<b>Beds</b>										
<b>Maximum Base</b>	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38	\$ 4,014.38
<b>Calculated Maximum:</b>										
<b>Base</b>	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64
<b>Beds above max</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Total per cost report</b>	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64
<b>Maximum Base</b>	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56	\$ 48,172.56
<b>Full Related Party Limit</b>	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64	\$ 33,200.64
<b>% of Administrator Limit</b>	60%	60%	60%	60%	60%	60%	60%	60%	60%	60%
<b>% of time devoted</b>										
<b>Maximum Compensation</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Excess Compensation (Sch B, Line 428)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Excess payroll taxes (7.65%) (Sch B Line 428)</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Sch D Line of Salary Adjustment</b>										
<b>Sch D Line of Benefit Adjustment</b>										

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:		NPI	
Period of Report:	From:	To:	

SCHEDULE G-1 - RELATED PARTY COMPENSATION LIMITS

Sch D Line of PR taxes Adjustment										
-----------------------------------	--	--	--	--	--	--	--	--	--	--

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	NPI
<b>Period of Report: From:</b>	<b>To:</b>

<b>SCHEDULE G-2 - CHANGE IN OWNERSHIP &amp; RELATED PARTY LEASE / PROPERTY EXPENSE</b>							
	<b>Nursing Facility</b>	<b>ICF/ID</b>	<b>ICF/MC</b>	<b>Assisted Living</b>	<b>Independent Living</b>	<b>Other</b>	<b>Total</b>
<b>Lease Payments</b>							\$ -
<b>Owner Basis:</b>							
Depreciation							\$ -
Amortization							\$ -
Real estate taxes							\$ -
Property interest							\$ -
Property and casualty insurance							\$ -
Building and grounds repairs							\$ -
Other							\$ -
<b>Allowable Basis</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>Reasonable Rate of Return<sup>1</sup></b>							
<b>Amount of Allowable cost</b>	\$ -	\$ -	\$ -				
<b>Sch D Line of Lease / Property Adjustment</b>							

<sup>1</sup> If claiming rate of return, provide detail calculation of amounts on a supporting schedule.

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	<b>NPI</b>
<b>Period of Report: From</b>	<b>To:</b>

<b>SCHEDULE H NURSING FACILITY WAGES AND HOURS</b>						
<b>Sch D Line No.</b>	<b>Occupation or Employment Category</b>	<b>Total Wages Schedule D NF (1)</b>	<b>Total Hours NF (2)</b>	<b>Average Hourly Wage NF (3)</b>	<b>Average Hours Per NF Patient Day (4)</b>	<b>Entry Level Hourly Wage (5) (Optional)</b>
1	Administrator wages	\$ -		\$ -		
2	Business Office wages	\$ -		\$ -		
3	Advertising and Marketing Wages	\$ -		\$ -		
36	Laundry wages	\$ -		\$ -		
37	Housekeeping wages	\$ -		\$ -		
38	Maintenance wages	\$ -		\$ -		
39	Environmental Universal Worker	\$ -		\$ -		
71	Director of nursing wages	\$ -		\$ -		
72	Administrative nursing (ADON, MDS, etc)	\$ -		\$ -		
73	Medical Records Services wages	\$ -		\$ -		
74	Medical Director wages	\$ -		\$ -		
75	Activities wages	\$ -		\$ -		
76	Social Services wages	\$ -		\$ -		
77	Dietary Service Wages	\$ -		\$ -		
78	Support Universal Worker	\$ -		\$ -		
98	Pharmacy consulting wages			\$ -		
101	Contracted professional support services			\$ -		
102	Professional support services			\$ -		
107	RN wages	\$ -		\$ -		
108	LPN wages	\$ -		\$ -		
109	Certified aides - CNA, CMA, etc wages	\$ -		\$ -		
110	Direct Care Universal Worker	\$ -		\$ -		
111	Therapy salaries - inpatient residents	\$ -		\$ -		
112	Therapy salaries - outpatient care	\$ -		\$ -		
113	Direct support professionals	\$ -		\$ -		
114	Other direct care wages	\$ -		\$ -		
126	Professional support - nurse consulting	\$ -		\$ -		
127	Contracted nursing services - RN, LPN	\$ -		\$ -		
128	Contracted nursing services - aides	\$ -		\$ -		



**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	0	<b>NPI</b>	
<b>Period of Report: From</b>	01/00/00	<b>To:</b>	01/00/00

**SCHEDULE I  
Nursing Facility Annual Calculation Of Employee Turnover**

**Total Number of Employees on the First day of each Month**

Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	Average for the Year
1	Administrator													0	0.00
2	Business Office													0	0.00
3	Advertising & Marketing													0	0.00
36	Laundry													0	0.00
37	Housekeeping													0	0.00
38	Maintenance													0	0.00
71	Director of nursing													0	0.00
72	Administrative nursing													0	0.00
73	Medical Record Wages													0	0.00
74	Medical Director													0	0.00
75	Activities													0	0.00
76	Social Services													0	0.00
77	Dietary Service													0	0.00
99	Pharmacy Consultant													0	0.00
110	R.N.													0	0.00
111	Licensed Practical Nurses													0	0.00
112	Certified Aides													0	0.00
114 - 117	Other Direct Care													0	0.00
39, 78, 113	Universal Worker													0	0.00
Various	Other Staff													0	0.00
<b>Total</b>		0	0	0	0	0	0	0	0	0	0	0	0	0	0.00

**Total Number of Terminations Each Month**

Sch C Line No.	Job Classification	January	February	March	April	May	June	July	August	September	October	November	December	Total	Average Turnover Rate
1	Administrator													0	0.00%
2	Business Office													0	0.00%
3	Advertising & Marketing													0	0.00%
36	Laundry													0	0.00%
37	Housekeeping													0	0.00%
38	Maintenance													0	0.00%
71	Director of nursing													0	0.00%
72	Administrative nursing													0	0.00%
73	Medical Record Wages													0	0.00%
74	Medical Director													0	0.00%
75	Activities													0	0.00%
76	Social Services													0	0.00%
77	Dietary Service													0	0.00%
99	Pharmacy Consultant													0	0.00%
110	R.N.													0	0.00%
111	Licensed Practical Nurses													0	0.00%
112	Certified Aides													0	0.00%
114 - 117	Other Direct Care													0	0.00%
39, 78, 113	Universal Worker													0	0.00%
Various	Other Staff													0	0.00%
<b>Total</b>		0	0	0	0	0	0	0	0	0	0	0	0	0	0.00%

<b>Nursing Turnover Only</b>	0.00%
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**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	0	<b>NPI</b>	
<b>Period of Report: From:</b>	01/00/00	<b>To:</b>	01/00/00

<b>ALLOCATION METHODS</b>								
<b>Allocation Base</b>	<b>Allocation Base Code</b>	<b>Total [01]</b>	<b>Nursing Facility [02]</b>	<b>ICF/ID [03]</b>	<b>ICF/MC [04]</b>	<b>Assisted Living [05]</b>	<b>Independent Living [06]</b>	<b>Other [07]</b>
Accumulated Costs	1							
Resident Days	2							
Bed Days Available	3							
Total Personnel Costs	4							
Square Feet	5							
Meals Served	6							
Lbs. of Laundry	7							
FTE's	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							
Other (Specify)	17							
Other (Specify)	18							
Other (Specify)	19							
Other (Specify)	20							
Other (Specify)	21							
Other (Specify)	22							
Other (Specify)	23							
Other (Specify)	24							
Other (Specify)	25							
Other (Specify)	26							

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	0	<b>NPI:</b>	
<b>Period of Report:</b>	<b>From:</b> 01/00/00	<b>To:</b>	01/00/00

**Quality Assurance Assessment Fee**

**Section 1: Reconciliation Of Quality Assurance Assessment Fee**

Statistical Information

Line No.	Type of Day	
1	Total Medicaid fee-for-service Days	
2	Total Medicaid Managed Care Days	
3	Total Medicare Part A and Part C	
4	Total Private Pay / Insurance Days	
5	Total Non-Medicaid Hospice Days	
6	Total Medicaid Hospice Days	
7	Total Veterans Affairs Days	
8	Total County Days	
9	Total Other Days	
10	Total patient days	0
11	Licensed beds during period	
12	Total bed days during period	0
13	Average occupancy during period	#DIV/0!
14	Average Medicaid utilization during period	#DIV/0!

Quality Assurance Assessment Fee Remitted

Line No.	Amounts reported in this section should agree with amounts from Quarterly Form 470-4836	
15	Quality assurance assessment fee per bed day	
16	Quality assurance assessment fee paid for 1st quarter	
17	Quality assurance assessment fee paid for 2nd quarter	
18	Quality assurance assessment fee paid for 3rd quarter	
19	Quality assurance assessment fee paid for 4th quarter	
20	Total quality assurance assessment fee paid for period	\$0.00

Quality Assurance Assessment Pass-through and Rate Add-on Payments Received

Line No.		
21	Quality assurance assessment payments received for 1st quarter	
22	Quality assurance assessment payments received for 2nd quarter	
23	Quality assurance assessment payments received for 3rd quarter	
24	Quality assurance assessment payments received for 4th quarter	
25	Quality assurance assessment payments received for period	\$0.00

Calculation of Enhanced Medicaid Payment Received and Spending Requirements

Line No.	Enhanced Medicaid payment is the amount of payments received over amount remitted	
26	Amount of Enhanced Medicaid Payment - if less than \$0, Sections 2 and 3 are not required	\$0.00
27	Amount of Enhanced Medicaid Payment to be expended on behalf of all employees (60%)	\$0.00
28	Amount of Enhanced Medicaid Payment to be expended on behalf of CNAs (35%)	\$0.00

**Section 2: Demonstration of Wage and Employment Cost Change for the Period**

**Any costs in this section MUST have a descriptive narrative in Section 3**

Line No.	Description	Increases for CNA wages and costs	Increases for other employee wages and costs	Total Increases for wages and costs
29	Wage increases			\$0.00
30	Bonuses and other wage adjustments			\$0.00
31	Changes to staffing patterns			\$0.00
32	Vacation, holiday and sick pay - PTO or leave benefits			\$0.00
33	Benefit programs - health, life and retirement			\$0.00
34	Education programs and advancement opportunities			\$0.00
35	Tuition reimbursement programs			\$0.00
36	Other costs			\$0.00
37	Total increases in wages and costs	\$0.00	\$0.00	\$0.00

**IOWA FINANCIAL AND STATISTICAL REPORT**

<b>Facility Name:</b>	0	<b>NPI:</b>	
<b>Period of Report:</b>	<b>From:</b> 01/00/00	<b>To:</b>	01/00/00
<b>Quality Assurance Assessment Fee</b>			

<b>Test of Required Increases</b>	
CNA	

Required amount to be expended on behalf of CNAs		\$0.00
Actual amount expended on behalf of CNAs		\$0.00
Test Met		TRUE

<b>All Employees</b>
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Required amount to be expended on behalf of all employees		\$0.00
Actual amount expended on behalf of all employees		\$0.00
Test Met		TRUE

<b>Section 3: Narrative</b>
<b>All costs from Section 2 MUST have a descriptive narrative</b>

**IOWA FINANCIAL AND STATISTICAL REPORT / SUPPLEMENTATION REPORT**

<b>Facility Name:</b>	0	<b>NPI.</b>	
<b>Period of Report:</b>	<b>From:</b>	01/00/00	<b>To:</b> 01/00/00

**Supplementation - Nursing Facility Only**

**Iowa Administrative Code 441 Chapter 81.10(5)e**

**Supplementation Questions:**

**Did the facility receive any supplementation for provision of a private room? (Y/N)**

**What is the total amount received for supplementation for a private room?**

**How many residents received a private room due to supplemental payments?**

**Average private pay charge for a private room?**

**Please describe how the average private pay charge is determined**

**Census at first day of the month:**

Month	# of Beds Available	Beds in Private Rooms	Beds in Semi-Private Rooms	Beds in Other Rooms	Bed Days (Beds * Number of Days in Month)	Total Resident Days (Midnight Census)	Occupancy Percentage
January					0		0.00%
February					0		0.00%
March					0		0.00%
April					0		0.00%
May					0		0.00%
June					0		0.00%
July					0		0.00%
August					0		0.00%
September					0		0.00%
October					0		0.00%
November					0		0.00%
December					0		0.00%
Totals					0	0	
Average							0.00%

**Resident information**

Resident Name	Medicaid Resident ID	Total Private Room Charge	Amount of Medicaid Reimbursement	Amount of Supplementation Charged to Resident

Facility Name:	NPI
Period of Report: From:	To:

SUPPORTING SCHEDULE (1)

IOWA FINANCIAL AND STATISTICAL REPORT

Facility Name:	NPI
Period of Report: From:	To:

SUPPORTING SCHEDULE (2)