

SUMMARY REPORT

NF - Cost Report for 2012

Prepared by
 Provider Name
 Date

Contract Number
 Period Ended

Item No.	Description	Item No.	Value
	2012 COST REPORT for TEXAS NURSING FACILITY (NF) (version: 12/31/12)		
	GENERAL INFORMATION		
1	DADS NF 9-digit Contract Number	1	
2	DADS NF 4-digit Facility Number	2	
3	Type Ownership of Facility	3	
4	Type Ownership of Contracting Entity (Complete Schedule H)	4	
5	Type Ownership of Parent Company, Sole Member, Governmental Body, or Related Party Management Company (Complete Schedule H)	5	
6	Texas Comptroller Identification Number (14 digits)	6	
	Item 7 reserved for future use.		
8	Texas County Code in Which Facility is Located	8	
9	Texas County Code in Which Accounting Records are Located (3 digits). "999" if not in Texas.	9	
10	Reporting Period - Beginning Date (mm/dd/yy)	10	
11	Reporting Period - Ending Date (mm/dd/yy) (If Reporting Period is less than a full year, provide reason in explanation box.)	11	
12	Is the facility a Medicare participant? (0=No, 1=Yes) If Yes, respond Yes to item 13 and include the facility's Medicare provider number in item 16. (If ancillary costs are reported, complete Schedule G.)	12	
13	Does any entity within "the entire related organization" hold any other contracts or grants with the State of Texas or with Medicare? (0=No, 1=Yes)	13	
14	Does any entity within "the entire related organization" administer any other business entities? (0=No, 1=Yes)	14	
15	If item 13 is Yes, give the total number of Texas Medicaid NF contracts (including this facility) and complete Schedule H. In the explanation box, list the 9-digit contract for each NF (including this facility).	15	
16	If items 12, 13 or 14 are Yes, give the total number of contracts/grants/business entities, within and outside the State of Texas, excluding only the Texas Medicaid contract numbers for the nursing facilities listed in item 15 and complete Schedule H. Include the Medicare contract numbers for the Texas nursing facilities listed in item 15, if applicable. In the explanation box, list the type of program (e.g., Medicare NF, Assisted Living Apartments, PHC/FC, Medicare Therapy company, etc.) and Contract or Provider number for each contract/grant/business entity.	16	
17	Was an accrual method of accounting used for reporting all revenues, expenses and statistical information on this cost report, except for specific line items where instructions allow reporting on a cash basis? (If No, give reason in the explanation box.) (0=No, 1=Yes)	17	
18	Were any equipment or supplies leased or purchased from a related party during the reporting period? (If Yes, complete Schedule B, Section 1A and/or 4.) (0=No, 1=Yes)	18	
19	Were any contracted or consultant services (including contracted management) provided by a related organization? (If Yes, complete Schedule B, Section 1A. If lending services, complete Schedule B, Section 2A.) (0=No, 1=Yes)	19	
20	Were any contracted or consultant services provided by a related individual? (If Yes, complete Schedule B, Section 1B. If lending services, complete Schedule B, Section 2B.) (0=No, 1=Yes)	20	
21	Did an owner-employee or other related party employee within "the entire related organization" work at the facility level? (If Yes, complete Schedule C even if no salaries or compensation were reported.) Attach an organizational chart and enter the attachment number in the explanation box. (0=No, 1=Yes)	21	
22	Did an owner-employee or other related party employee within "the entire related organization" work as the facility Administrator? (If Yes, complete Schedule C even if no salaries or compensation were reported.) Attach an organizational chart and enter the attachment number in the explanation box. (0=No, 1=Yes)	22	

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23	Did an owner-employee or other related party employee within "the entire related organization" work as the facility Assistant Administrator? (If Yes, complete Schedule C even if no salaries or compensation were reported.) Attach an organizational chart and enter the attachment number in the explanation box. (0=No, 1=Yes)	23	
24	Did an owner-employee or other related party employee within "the entire related organization" work at the central office, shared administration, or related-party management level? (If Yes, complete Schedule C even if no salaries or compensation were reported.) Attach an organizational chart and enter the attachment number in the explanation box. (0=No, 1=Yes)	24	
25	Was the nursing facility building leased during the cost-reporting period? (If Yes, complete Schedule D1 and attach a copy of the signed lease. Enter attachment number in the explanation box. If leased from a related party, also complete Schedule B, Sections 1A and 3A.) (0=Not Leased, 1=Leased from non-related party, 2 = Leased from related party)	25	
26	Was the central office/shared administration/related party management building leased during the cost-reporting period? (If Yes, complete Schedule D2. If leased from a related party, also complete Schedule B, Sections 1A and 3A.) (0=Not Leased, 1=Leased from non-related party, 2 = Leased from related party)	26	
27	Was the nursing facility building purchased from a related party? (If Yes, complete Schedule B, Sections 1A and 4.) (0=No, 1=Yes)	27	
28	Were any contracted management costs (non-related party or related party) reported on this cost report? (If Yes, complete Schedule E) Related Party management expenses must be reported as central office expenses. (0=No, 1=Yes, from a non-related party, 2=Yes, from a related party)	28	
29	Are any self-insurance expenses reported on this cost report? If Yes, answer Yes to all insurance categories in items 30 thru 36 which have self-insurance expenses reported on this cost report. (0=No, 1=Yes)	29	
30	If item 29 is Yes, were Buildings and Contents self-insurance expenses reported on this cost report? (1=Yes)	30	
31	If item 29 is Yes, were General Liability self-insurance expenses reported on this cost report? (1=Yes)	31	
32	If item 29 is Yes, were Professional Malpractice self-insurance expenses reported on this cost report? (1=Yes)	32	
33	If item 29 is Yes, were Vehicle self-insurance expenses reported on this cost report? If Yes, attach an approval from the Texas Department of Insurance for you to be self-insured for vehicle liability coverage and enter the attachment number in the explanation box. (1=Yes)	33	
34	If item 29 is Yes, were Health/Disability self-insurance expenses reported on this cost report? (1=Yes)	34	
35	If item 29 is Yes, were Workers' Compensation/Costs related to employee on-the-job injuries self-insurance expenses reported on this cost report? (1=Yes)	35	
36	If item 29 is Yes, were self-insurance expenses Other than the types indicated in items 30 thru 35 reported on this cost report? (1=Yes)	36	
37	For any category of self-insurance answered Yes in items 30 thru 36, did the expenses incurred exceed the allowable cost ceiling? For each category that exceeds its allowable cost ceiling, attach detail showing calculation of the cost ceiling, reported expenses, and carry forward amounts. Enter attachment number in the explanation box. (1=Yes)	37	
38	Have copies been attached of the 2011 or 2012 On-Line General and NF Cost Report Training Certificate(s) or a 2011 or 2012 Classroom-based First Time Attendee General and NF Cost Report Training Certificate(s) for each preparer signing this cost report? Enter attachment number(s) in the explanation box. (0=No, 1=Yes)	38	
39	Did the preparer(s) of this cost report review the audit adjustments for the prior year's cost report and make all the necessary revisions when preparing this cost report? (If No, give reason in explanation box.) (0=No, 1=Yes)	39	
40	Are there work papers that clearly reconcile between the fiscal year end trial balance and the amounts reported on this cost report? (If No, give reason in explanation box.) (0=No, 1=Yes)	40	

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41	Were any expenses reported on this cost report the result of the allocation of expenses (including the allocation of expenses between line items with the cost report)? If Yes, attach a detailed allocation summary showing allocation of 100% of the shared costs. Enter attachment number(s) in the explanation box. (0=No, 1=Yes)	41	
42	If item 41 is Yes, was Square Footage method used to allocate expenses onto this cost report? (1=Yes)	42	
43	If item 41 is Yes, was Units of Service method used to allocate expenses onto this cost report? (1=Yes)	43	
44	If item 41 is Yes, was Salaries method used to allocate expenses onto this cost report? (1=Yes)	44	
45	If item 41 is Yes, were Labor Cost methods used to allocate expenses onto this cost report? (1=Yes)	45	
46	If item 41 is Yes, was Cost-To-Cost method used to allocate expenses onto this cost report? (1=Yes)	46	
47	If item 41 is Yes, was Total Cost Less Facility Cost method used to allocate expenses onto this cost report? (1=Yes)	47	
48	If item 41 is Yes, was Functional method used to allocate expenses onto this cost report? (1=Yes)	48	
49	If item 41 is Yes, was Time Study method used to allocate expenses onto this cost report? (1=Yes)	49	
50	If item 41 is Yes, was an Other Method Approved by Rate Analysis used to allocate expenses onto this cost report? If Yes, attach approval letter from HHSC Rate Analysis and enter the attachment number in the explanation box. (1=Yes)	50	
51	Number of facility beds licensed for nursing care by DADS at the end of the cost-reporting period.	51	
52	Did the number of licensed beds change during the reporting period? (If Yes, complete Schedule I.) (0=No, 1=Yes)	52	
53	Number of licensed nursing beds contracted for Medicaid nursing care by DADS at the end of the cost-reporting period.	53	
54	Did the number of contracted beds change during the reporting period? (If Yes, complete Schedule I) (0=No, 1=Yes)	54	
55	During the 2012 cost-reporting period, was the facility Medicaid-decertified for any period of time? (0=No, 1=Yes)	55	
56	If item 55 is Yes, for how many days? NOTE: If the facility was decertified for more than 30 days during its 2012 cost-reporting period, this cost report should cover the period subsequent to recertification. Costs accrued prior to or during the period of decertification are not to be included on this cost report, including costs to get recertified.	56	
57	The only nurse aides to be included in items 108 thru 111 and 129 thru 132 of on this report are Certified Nurse Aides and nurse aides in training who have completed at least the first 16 hours of a Nurse Aide Training and Competency Evaluation Program (NATCEP). Have you excluded all time worked before sixteen hours of training are completed as well as associated salaries and wages from this report? NOTE: Excluded hours and salaries and wages should be reported in items 160 and 161. (0=No, 1=Yes)	57	
58	Does this facility provide an in-house NATCEP? (0=No, 1=Yes)	58	
59	Reserved for future use.	59	
60	Select the address to which all future correspondence concerning this report is to be mailed. These two choices correspond to the addresses indicated on the first page (cover) of this cost report. (0=facility, 1=contracting entity)	60	
61	Total number of central office staff employed by the controlling entity on the last day of the cost-reporting period.	61	
62	Total number of non-central office staff employed by the contracted provider on the last day of the cost-reporting period.	62	
63	Of the central office employees included in item 61, how many worked 30 hours or less a week?	63	
64	Of the non-central office employees included in item 62, how many worked 30 hours or less a week?	64	
65	Did the company offer health insurance to its employees on or before March 23, 2010? (0 = No, 1 = Yes)	65	
66	If item 65 is yes, is that coverage still in effect? (0 = No, 1 = Yes)	66	
67	Does the company have more than 50 full-time employees? (Full-time means persons who work more than 30 hours a week on average) (0 = No, 1 = Yes)	67	
68	Does the company have more than 200 full-time employees? (0 = No, 1 = Yes)	68	

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69	Does the health insurance the company offers include all of the following benefits: inpatient, outpatient and emergency services; maternity and newborn care; mental and behavioral health services; prescription drugs; rehabilitation and habilitation services; laboratory services; disease management; preventative and wellness services; pediatric care? (If the company does not offer health insurance, answer No.) (0 = No, 1 = Yes)	69	
	RESIDENT DAYS AND REVENUE: MEDICAID-CONTRACTED BEDS		
70	Medicaid Residents (Include Applied Income) 70 = Days of Service; 71 = Revenue	70	
71		71	
72	Hospice Residents (Include Applied Income) 72 = Days of Service; 73 = Revenue	72	
73		73	
74	STAR+PLUS Managed Care Residents: 74 = Days of Service, 75 = Revenue	74	
75		75	
76	Medicare Residents in Medicaid-contracted beds: 76 = Days of Service, 77 = Revenue	76	
77		77	
78	V.A. Residents in Medicaid-contracted beds: 78 = Days of Service, 79 = Revenue	78	
79		79	
80	Private Insurance Residents in Medicaid-Contracted beds: 80 = Days of Service, 81 = Revenue	80	
81		81	
82	Private Residents in Medicaid-Contracted beds: 82 = Days of Service, 83 = Revenue	82	
83		83	
	RESIDENT DAYS AND REVENUE: NON-MEDICAID-CONTRACTED BEDS		
84	Medicare Residents in Medicare-Certified-Only Beds: 84 = Days of Service, 85 = Revenue	84	
85		85	
86	Other Residents in Non-Medicaid contracted Beds: 86 = Days of Service, 87 = Revenue	86	
87		87	
88	TOTAL DAYS OF SERVICE FOR ALL BEDS (sum items 70, 72, 74, 76, 78, 80, 82, 84, 86)	88	
	NOTE: Total reported Days of Service must not exceed the amount equal to the number of licensed beds multiplied by the number of days of operation during the cost-reporting period. In addition, the total reported Days of Service for Medicaid contracted beds must not exceed the amount equal to the number of Medicaid-contracted beds multiplied by the number of days of operation during the reporting period.		
	OTHER REVENUES		
89	Room and Bed Holds	89	
90	Gifts, Grants, Donations, Endowments and Trusts	90	
91	Appropriations from State or Local Government Sources	91	
92	Interest - Funded Depreciation Account; Qualified Pension Fund; Debt Service Reserve Fund	92	
93	Gain on Sale of Assets (Provide description in explanation box)	93	
94	Other - Excess of Other Revenues Over Direct Expenses (From Schedule F)	94	
95	TOTAL OF ALL REPORTABLE REVENUE (sum items 71, 73, 75, 77, 79, 81, 83, 85, 87, and 89 thru 94)	95	
96	Bad Debt and Charity or Courtesy Allowance	96	
97	TOTAL NET REPORTABLE REVENUE (item 95 minus item 96)	97	

Items 98 thru 101 reserved for future use.

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Item No.	Description	Item No.	Value
DIRECT CARE - STAFF COSTS - MEDICAID CONTRACTED BEDS			
If a related party employee, complete Schedule C			
102	Registered Nurses: 102 = Paid Hours, 103 = Salaries & Wages	102	
103		103	
104	Licensed Vocational Nurses: 104 = Paid Hours, 105 = Salaries & Wages	104	
105		105	
106	Medication Aides: 106 = Paid Hours, 107 = Salaries & Wages	106	
107		107	
108	Restorative Aides: 108 = Paid Hours, 109 = Salaries & Wages	108	
109		109	
110	Nurse Aides: 110 = Paid Hours, 111 = Salaries & Wages	110	
111		111	
112	Employee Benefits / Insurance - Direct Care Staff (Provide description in the explanation box)	112	
113	Contract - Registered Nurses: 113 = Paid Hours, 114 = Compensation	113	
114		114	
115	Contract - Licensed Vocational Nurses: 115 = Paid Hours, 116 = Compensation	115	
116		116	
117	Contract - Medication Aides: 117 = Paid Hours, 118 = Compensation	117	
118		118	
119	Contract - Certified Nurse Aides: 119 = Paid Hours, 120 = Compensation	119	
120		120	
Items 121 thru 122 reserved for future use.			
DIRECT CARE - STAFF COSTS - NON-MEDICAID CONTRACTED BEDS			
If a related party employee, complete Schedule C			
123	Registered Nurses: 123 = Paid Hours; 124 = Salaries & Wages	123	
124		124	
125	Licensed Vocational Nurses: 125 = Paid Hours, 126 = Salaries & Wages	125	
126		126	
127	Medication Aides: 127 = Paid Hours, 128 = Salaries & Wages	127	
128		128	
129	Restorative Aides: 129 = Paid Hours, 130 = Salaries & Wages	129	
130		130	
131	Nurse Aides: 131 = Paid Hours, 132 = Salaries & Wages	131	
132		132	
133	Employee Benefits / Insurance - Direct Care Staff (Provide description in the explanation box)	133	
134	Contract - Registered Nurses: 134 = Paid Hours, 135 = Compensation	134	
135		135	
136	Contract - Licensed Vocational Nurses: 136 = Paid Hours, 137 = Compensation	136	
137		137	
138	Contract - Medication Aides: 138 = Paid Hours, 139 = Compensation	138	
139		139	
140	Contract - Certified Nurse Aides: 140 = Paid Hours, 141 = Compensation	140	
141		141	
RESIDENT CARE - OTHER RESIDENT CARE COSTS			
If a related party employee, complete Schedule C			
142	Certified Social Workers: 142 = Paid Hours, 143 = Salaries & Wages	142	
143		143	
144	Social Service Assistants: 144 = Paid Hours, 145 = Salaries & Wages	144	
145		145	

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Item No.	Description	Item No.	Value
146	Activity Director: 146 = Paid Hours, 147 = Salaries & Wages	146	
147		147	
148	Activity Services Assistants: 148 = Paid Hours, 149 = Salaries & Wages	148	
149		149	
150	Medical Records Staff: 150 = Paid Hours, 151 = Salaries & Wages	150	
151		151	
152	Resident Care Training Staff 152 = Paid Hours; 153 = Salaries & Wages	152	
153		153	
154	Central Supply Staff: 154 = Paid Hours, 155 = Salaries & Wages	154	
155		155	
156	Laundry and Housekeeping Staff: 156 = Paid Hours, 157 = Salaries & Wages	156	
157		157	
158	Other Resident Care Staff - Professional: (Provide description in the explanation box) 158 = Paid Hours, 159 = Salaries & Wages	158	
159		159	
160	Other Resident Care Staff - Nonprofessional: (Provide description in the explanation box) 160 = Paid Hours, 161 = Salaries & Wages	160	
161		161	
162	Employee Benefits / Insurance - Other Resident Care Staff (Provide description in the explanation box)	162	
	RESIDENT CARE - CONSULTANTS		
	If a related party consultant, complete Schedule B, Section 1B		
163	Medical Director	163	
164	Registered Nurse	164	
165	Pharmacist	165	
166	Social Worker	166	
167	Activity Director	167	
168	Medical Records	168	
169	Other Resident Care Consultants (Provide description in the explanation box)	169	
	RESIDENT CARE - CONTRACTED SERVICES/SUPPLIES/OTHER RESIDENT CARE EXPENSES		
170	Contracted Services: In-service Training - Resident Care Staff (Provide description in explanation box)	170	
171	Contracted Services: Activities	171	
172	Contracted Services: Social Services	172	
173	Contracted Services: Laundry and Housekeeping	173	
174	Supplies: Nursing and Medical	174	
175	Supplies: In-service Training - Resident Care Staff (Provide description in the explanation box.)	175	
176	Supplies: Activities	176	
177	Supplies: Social Services	177	
178	Supplies: Laundry and Housekeeping	178	
179	Off-site Training/Seminars - Resident Care Staff	179	
180	Travel - Resident Care Staff	180	
181	Bio-Hazard Waste Disposal	181	
182	Other Resident Care Expenses (Provide description in the explanation box)	182	
	RESIDENT CARE - ANCILLARY SERVICES - MEDICAID-ONLY RESIDENTS		
	Only costs incurred for providing ancillary services to Medicaid-Only Residents may be reported.		
	Schedule G MUST be completed to support the ancillary costs reported below.		
	If a related party transaction, complete Schedule B and/or C		
183	Ancillary Therapists: 183 = Paid Hours, 184 = Salaries & Wages	183	
184		184	

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Item No.	Description	Item No.	Value
185	Ancillary Therapy Assistants: 185 = Paid Hours, 186 = Salaries & Wages	185	
186		186	
187	Other Ancillary Staff: 187 = Paid Hours, 188 = Salaries & Wages	187	
188		188	
189	Employee Benefits / Insurance - Ancillary Staff (Provide description in the explanation box)	189	
190	Therapy Supplies	190	
191	Physical Therapy Consultant	191	
192	Occupational Therapy Consultant	192	
193	Speech Therapy Consultant	193	
194	Contract and Off-Site Therapy	194	
195	Nutritional Therapy Supplies (nutritional therapy food supplements reported on item 234)	195	
196	Diagnostic Laboratory and Radiology	196	
197	Medical and Nursing Supplies	197	
198	Incontinent Supplies	198	
199	Drugs and Pharmaceuticals	199	
200	Oxygen	200	
201	DME Purchased by Provider	201	
202	DME Rental/Lease Expense	202	
203	TOTAL ANCILLARY SERVICE EXPENSES (sum 184, 186 and 188 thru 202) NOTE: Item 203 Must Equal Total of Schedule G, Section 1 - Column F	203	
204	TOTAL DIRECT CARE STAFF AND OTHER RESIDENT CARE COSTS (sum items 103, 105, 107, 109, 111, 112, 114, 116, 118, 120, 124, 126, 128, 130, 132, 133, 135, 137, 139, 141, 143, 145, 147, 149, 151, 153, 155, 157, 159, 161, 162 thru 182, plus 203)	204	
Items 205 thru 224 reserved for future use.			
DIETARY CARE COSTS			
If a related party transaction, complete Schedules B and/or C			
225	Food Service Supervisory and Professional Staff: 225 = Paid Hours, 226 = Salaries & Wages	225	
226		226	
227	Other Food Service Staff: 227 = Paid Hours, 228 = Salaries & Wages	227	
228		228	
229	Employee Benefits / Insurance - Food Service Staff (Provide description in the explanation box)	229	
230	Contracted - Dietitian/Nutritionist: 230 = Paid Hours, 231 = Compensation	230	
231		231	
232	Contract Dietary Services	232	
233	Supplies - Food	233	
234	Supplies - Food for ancillary nutritional supplements for Medicaid-only residents (from Schedule G)	234	
235	Supplies - Dietary Nonfood	235	
236	Other Dietary Costs (Provide description in the explanation box)	236	
237	TOTAL DIETARY CARE COSTS (sum items 226, 228, 229, and 231 thru 236)	237	
Items 238 thru 248 reserved for future use.			
FACILITY COSTS			
(If a related party transaction, complete Schedules B and/or C)			
249	Maintenance Staff: 249 = Paid Hours, 250 = Salaries & Wages	249	
250		250	
251	Employee Benefits / Insurance - Maintenance Staff (Provide description in the explanation box)	251	

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Item No.	Description	Item No.	Value
252	Lease - Nursing Facility Building(s) (Complete Schedule D1)	252	
253	Lease/Rental - Building and/or Facility Equipment and Facility Other (e.g., storage building)	253	
254	Insurance - Buildings, Contents and Grounds	254	
255	Interest - Mortgage	255	
256	Interest - Other Facility/Operations Notes	256	
257	Tax - Ad Valorem Real Estate	257	
258	Utilities - Electricity, Gas, Water and Wastewater, Garbage Disposal	258	
259	Maintenance and Repairs - Buildings, Building Equipment and Grounds	259	
260	Contract Services - Building/Facility/Operations (Provide description in the explanation box)	260	
261	Depreciation - Buildings/Facility (from Schedules A, item 1 and/or B, Section 1A and 4, item 1)	261	
262	Depreciation - Building Fixed Equipment (from Schedules A, item 2 and/or B, Section 1A and 4, item 2)	262	
263	Depreciation - Land Improvements (from Schedules A, item 3 and/or B, Section 1A and 4, item 3)	263	
264	Amortization - Leasehold Improvements (from Schedules A, item 4 and/or B, Section 1A and 4, item 4)	264	
265	Total Facility Costs (sum items 250 thru 264)	265	
Items 266 thru 268 reserved for future use.			
OPERATIONS COSTS (If a related party transaction, complete Schedules B and/or C)			
269	Lease/Rental - Transportation Equipment	269	
270	Lease/Rental - Departmental Equipment	270	
271	Insurance - Transportation Equipment	271	
272	Insurance - Operations Other	272	
273	Tax - Personal Property/Operations/Other Taxes	273	
274	Utilities - Telecommunications	274	
275	Maintenance - Facility/Operations/Other Supplies	275	
276	Maintenance and Repairs - Departmental Equipment	276	
277	Maintenance, Repairs, Gas, Oil - Transportation Equipment	277	
278	Other Building and/or Facility/Operations Expenses (Provide description in the explanation box)	278	
279	Depreciation - Departmental Equipment (from Schedules A, item 5 and/or B, Section 1A and 4, item 5)	279	
280	Depreciation - Durable Medical Equipment (DME) (from Schedules A, item 6 and/or B, Section 1A and 4, item 6)	280	
281	Depreciation - Transportation Equipment (from Schedules A, item 7 and/or B, Section 1A and 4, item 7)	281	
282	Amortization - Other (from Schedules A, item 8 and/or B, Section 1A and 4, item 8)	282	
283	Total Operations Costs (sum items 269 thru 282)	283	
284	TOTAL FACILITY AND OPERATIONS COSTS (sum items 265 and 283)	284	
Items 285 thru 299 reserved for future use.			
ADMINISTRATION COSTS			
If a related party transaction, complete Schedules B and/or C			
300	Facility Administrator: 300 = Paid Hours, 301 = Salaries & Wages	300	
301		301	
302	Assistant Administrator: 302 = Paid Hours, 303 = Salaries & Wages	302	
303		303	
304	Owner, Partner, Stockholder: (See note on item 312) (Complete Schedule C) 304 = Paid Hours, 305 = Salaries & Wages	304	
305		305	
306	Professional Administrative Staff 306 = Paid Hours; 307 = Salaries & Wages	306	
307		307	
308	Clerical and Secretarial Staff (308 = Paid Hours, 309 = Salaries & Wages)	308	
309		309	

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310	Employee Benefits/Insurance - Facility Administrator (Provide description in explanation box)	310	
311	Employee Benefits/Insurance - Assistant Administrator (Provide description in explanation box)	311	
312	Employee Benefits/Insurance - Owner, Partner, Stockholder (Provide description in explanation box and complete Schedule C.)	312	
NOTE: Complete items 304, 305 and 312 only if an owner, Partner, or Stockholder is employed in an administration position other than facility Administrator, Asst Administrator, or central office.			
313	Employee Benefits/Insurance - Professional Administration Staff (Provide description in explanation box)	313	
314	Employee Benefits/Insurance - Clerical and Secretarial Staff (Provide description in explanation box)	314	
315	Fees - Management Contract (nonrelated party only) (Complete Schedule E)	315	
316	Fees - Professional Services/Consulting/Licenses and Permits/Other (Provide description in the explanation box)	316	
317	Contract Administrative Services	317	
318	Insurance - General Liability/Professional Malpractice - Premiums	318	
319	Insurance - General Liability/Professional Malpractice - Paid Claims, Deductibles, Co-insurance	319	
320	Insurance - Other	320	
321	Interest - Working Capital Loans	321	
322	Tax - Texas Corporate Franchise Tax	322	
323	Advertising	323	
324	Travel, Training and Seminars - Administrative Staff	324	
325	Dues - Association Dues/Subscriptions/Other Dues (Provide description in the explanation box)	325	
326	Office Supplies/Other Administrative Expenses (Provide description in the explanation box)	326	
Items 327 thru 332 reserved for future use.			
EXPENSES for CENTRAL OFFICE / ALLOCATED SHARED ADMINISTRATION / and RELATED PARTY MANAGEMENT			
If central office expenditures involved transactions with related parties, complete Schedule B and/or C.			
333	Salaries and Wages (excluding ancillary staff)	333	
334	Payroll Taxes and Workers' Compensation (excluding ancillary staff)	334	
335	Employee Benefits (excluding ancillary staff) (Provide description in explanation box)	335	
336	Salaries and Wages - Ancillary Indirect Medicaid-Only (From Schedule G)	336	
337	Payroll Taxes and Workers' Comp. - Ancillary Indirect Medicaid-Only (From Schedule G)	337	
338	Employee Benefits - Ancillary Indirect Medicaid-Only (From Schedule G) (Provide description in explanation box)	338	
339	Advertising	339	
340	Travel, Training and Seminars - Central Office Staff	340	
341	Association Dues / Other Dues	341	
342	Fees - Professional Services/Consulting/Other	342	
343	Rental and Lease	343	
344	Depreciation & Amortization (from Schedules A, item 9 and/or B, Section 4, item 9)	344	
345	Interest	345	
346	Ad Valorem Property Tax	346	
347	Texas Corporate Franchise Tax	347	
348	Insurance - General Liability/Professional Malpractice - Premiums	348	
349	Insurance - General Liability/Professional Malpractice - Paid Claims, Deductibles, Co-insurance	349	
350	Insurance - Other	350	
351	Operations and Maintenance	351	
352	Office Supplies/Other Central Office Expenses (Provide description in explanation box)	352	
353	TOTAL Central Office Expenses (sum items 333 thru 352)	353	

SUMMARY REPORT

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Date				
Item No.	Description	Item No.	Value	
354	TOTAL ADMINISTRATION COSTS (sum items 301, 303, 305, 307, 309, 310 thru 326, and 353)	354		
	Items 355 thru 374 reserved for future use.			
	PAYROLL TAXES			
375	FICA and Medicare	375		
376	State and Federal Unemployment	376		
377	TOTAL Payroll Taxes (sum items 375 and 376)	377		
378	Does item 375 equal 7.65% of total salaries reported (excluding central office)? (If No, provide a detailed explanation in the explanation box.) (0=No, 1=Yes)	378		
379	Is the facility/provider required to pay quarterly taxes to the Texas Workforce Commission for unemployment coverage? (If No, provide a detailed explanation in the explanation box.) (0=No, 1=Yes)	379		
	Items 380 thru 385 reserved for future use.			
	WORKERS' COMPENSATION			
386	Insurance Premiums	386		
387	Paid Claims	387		
388	Texas Workers' Compensation Commission Certified Self-Insurance (Attach "Certificate of Authority to Self-Insure", enter attachment number in the explanation box)	388		
389	Contributions to a Special Risk Management Pool/Fund	389		
390	TOTAL WORKERS' COMPENSATION (sum items 386 thru 389)	390		
	Items 391 thru 399 reserved for future use.			
	EXPENSE SUMMARY			
	NOTE: This summary of expenses is intended for Texas Medicaid cost-reporting purposes only! The facility may have incurred expenses in addition to those shown here.			
400	TOTAL Direct Care Staff and Other Resident Care Costs (From item 204)	400		
401	TOTAL Dietary Care Costs (From item 237)	401		
402	TOTAL Facility and Operations Costs (From item 284)	402		
403	TOTAL Administration Costs (From item 354)	403		
404	TOTAL Payroll Taxes (From item 377)	404		
405	Workers' Compensation (From item 390)	405		
406	TOTAL Net Reportable Expense (sum items 400 thru 405)	406		
	Section 2, Senate Bill 48, 79th Regular Session, 2005 amended Chapter 32 of the Texas Human Resources Code, 32.028 by adding Subsection (n) which requires HHSC to ensure that rules governing the determination of rates paid for nursing home services provide for the reporting of all revenue and costs, without regard to whether a cost is an allowable cost for reimbursement under the medical assistance program. The following item is included in the cost report to meet this statutory requirement. Please note that the information gathered by this item is self-reported, will not be audited, is for informational purposes only and will not be used in the rate determination process. Some costs included in this item may not be allowable in the current reporting period but will be reported as allowable in future years.			
407	TOTAL Unallowable Expenses	407		
	Items 408 thru 414 reserved for future use.			

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Item No.	Description	Item No.	Value
PROPERTY VALUES			
STATUS: Mark the "Yes" box next to the statement that describes the status of the facility for the current reporting period and report property values as indicated.			
415	Not Exempt - Check the "Yes" box for this line item and report on items 421 thru 424 the appraised property values for both land and improvements as stated on tax statements issued by the provider's local taxing authority for the 2011 or 2012 tax years. Attach a copy of the tax statement(s) reflecting these values AND indicate the attachment number in the explanation box. (1 = Yes)	415	
416	Exempt - Governmental Entity. The nursing facility building is owned by a governmental entity that is exempt from paying property taxes. Check the "Yes" box for this line item and leave items 419 thru 424 blank. (1 = Yes)	416	
417	Exempt - With Appraisal From Local Taxing Authority. The nursing facility is exempt from paying property taxes, but the local taxing authority DID issue an appraised value statement for the 2011 or 2012 tax years. Check the "Yes" box for this line item and report on items 421 thru 424 the appraised property values as stated on the tax statements for both land and improvements. Attach a copy of the tax statement(s) reflecting these values AND indicate the attachment number in the explanation box. (1 = Yes)	417	
418	Exempt - Without Appraisal From Local Taxing Authority. Your local taxing authority DID NOT issue an appraised value statement for the 2011 or 2012 tax years. Check the "Yes" box for this line item. An appraisal of the facility from an independent appraiser must be obtained. See cost report instructions for specific details on how to report values and what must be attached on this cost report. Indicate the attachment number in the explanation box. (1=Yes)	418	
419	If 418 is Yes, were capital improvements costing more than \$2,000 per licensed bed made to facility since the last independent appraisal was completed? (0=No, 1=Yes)	419	
420	Do the values shown on the taxable value statement or independent appraisal represent property solely devoted to nursing facility operations related to the beds LICENSED for NURSING care reported in line item 51? (0=No, 1=Yes)	420	
APPRAISED VALUES			
421	Year of valuation for appraised values reported.	421	
422	Appraised Value of Buildings and Other Improvements (excluding personal property)	422	
423	Appraised Value of Land	423	
424	TOTAL APPRAISED VALUE OF LAND AND IMPROVEMENTS (sum items 422 and 423)	424	
EMPLOYEE TURNOVER - STAFF EMPLOYED DURING THE COST-REPORTING PERIOD			
425	RNs	425	
426	LVNs	426	
427	Nurse Aides	427	
428	TOTAL Staff Employed During the Cost-Reporting Period (sum items 425 thru 427)	428	
EMPLOYEE TURNOVER - NORMAL STAFFING AT END OF COST-REPORTING PERIOD			
429	RNs	429	
430	LVNs	430	
431	Nurse Aides	431	
432	TOTAL Normal Staffing At The End Of The Cost-Reporting Period (sum items 429 thru 431)	432	
Items 433 thru 439 reserved for future use.			
NURSING FACILITY SQUARE FOOTAGE			
440	Square Footage of NF Resident Living Areas	440	
441	Square Footage of NF Resident Common Areas	441	
442	Square Footage of NF Non-Resident Areas	442	
443	TOTAL NURSING FACILITY SQUARE FOOTAGE (sum items 440 thru 442)	443	

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Prepared by Provider Name Date		Contract Number Period Ended		
Item No.	Description		Item No.	Value
	Items 444 thru 497 reserved for future use.			
	DIRECT CARE STAFF AND COMPENSATION INFORMATION			
498	Only those providers who participated in the Direct Care Staff and Compensation Rate Enhancement Program for the entire cost reporting period, identified as the Reporting Period Beginning Date (item 10) and Reporting Period Ending Date (item 11) must complete items 499 thru 983. Did this contract participate in Direct Care Staff and Compensation Rate Enhancement Program for its ENTIRE reporting period? (0 = No, 1 = Yes)		498	
	Call (512) 491-1354 if you have questions regarding the information requested in items 498 thru 983.			
499	Is this facility part of an organization that is requesting to have all of its participating nursing facility (NF) contracts evaluated in the aggregate for compliance with spending requirements? (If Yes, complete Schedule J) (0=No, 1=Yes)		499	
500	If item 499 is Yes, give the total number of NF contracts to be evaluated in the aggregate. NOTE: The number of contracts indicated here must match the number of contracts listed on Schedule J. Contracts not participating in the NF enhancement program may not be included in the aggregate group.		500	
501	(Health and Human Services Use Only) Group Number		501	
	Items 502 thru 589 reserved for future use.			
	DIRECT CARE STAFF PAYROLL TAXES & WORKERS' COMPENSATION - Medicaid Contracted Beds Only			
	Report in items 590 thru 595 the payroll taxes and workers' compensation expenses for direct care staff for Medicaid contracted beds only for this reporting period. The amounts reported in items 590 thru 595 are also to be included in the total amount reported in items 375 thru 390. No adjustment to reduce the payroll taxes and workers' compensation expenses to remove direct care staff payroll taxes and workers' compensation expenses reported in items 375 thru 390 should be made.			
590	Payroll Taxes - FICA and Medicare		590	
591	Does item 590 equal 7.65% of the sum of items 103, 105, 107, 109, and 111? (0=No, 1=Yes) (If No, give reason in explanation box.)		591	
592	State and Federal Unemployment (If none, give reason in the explanation box.)		592	
593	Workers' Compensation - Insurance Premiums		593	
594	Workers' Compensation - Paid Claims		594	
595	TOTAL Direct Care Staff Payroll Taxes and Worker's Compensation for Medicaid Contracted Beds Only (sum items 590 and 592 thru 594)		595	
	Items 596 thru 599 reserved for future use.			
	DIETARY STAFF TAXES and WORKERS' COMPENSATION			
	Report in items 600 thru 605 the payroll taxes and workers' compensation expenses for dietary staff for all licensed nursing facility beds for this reporting period. The amounts reported in items 600 thru 605 are also to be included in the total amount reported in line items 375 thru 390. No adjustment to reduce the payroll taxes and workers' compensation expenses to remove dietary staff payroll taxes and workers' compensation expenses reported in items 375 thru 390 should be made.			
600	Payroll Taxes - FICA and Medicare		600	
601	Does item 600 equal 7.65% of the sum of items 226 and 228? (0=No, 1=Yes) (If No, give reason in the explanation box.)		601	
602	State and Federal Unemployment (If none, give reason in the explanation box.)		602	
603	Workers' Compensation - Insurance Premiums		603	

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Item No.	Description	Item No.	Value
604	Workers' Compensation - Paid Claims	604	
605	TOTAL Dietary Staff Payroll Taxes and Worker's Compensation for all licensed nursing beds (sum items 600 and 602 thru 604)	605	
DAYS OF SERVICE IN MEDICAID-CONTRACTED BEDS		02/01/11 thru 08/31/11	
(include no decimals)			
This report can accommodate a date range of 23 months.			
ONLY COMPLETE THE UNITS OF SERVICE LINES FOR THE REPORTING PERIOD OF THIS COST REPORT AS ENTERED IN LINE ITEMS 10 and 11.			
GROUP	Medicaid Days Fee for Service (FFS)	Medicaid Days Hospice	Medicaid Days STAR+Plus
606	RUG RAD - 606 = Medicaid FFS; 607 = Medicaid Hospice; 608 = STAR+Plus		606
607			607
608			608
609	RUG RAC 609 = Medicaid FFS; 610 = Medicaid Hospice; 611 = STAR+Plus		609
610			610
611			611
612	RUG RAB 612 = Medicaid FFS; 613 = Medicaid Hospice; 614 = STAR+Plus		612
613			613
614			614
615	RUG RAA 615 = Medicaid FFS; 616 = Medicaid Hospice; 617 = STAR+Plus		615
616			616
617			617
618	RUG SE3 618 = Medicaid FFS; 619 = Medicaid Hospice; 620 = STAR+Plus		618
619			619
620			620
621	RUG SE2 621 = Medicaid FFS; 622 = Medicaid Hospice; 623 = STAR+Plus		621
622			622
623			623
624	RUG SE1 624 = Medicaid FFS; 625 = Medicaid Hospice; 626 = STAR+Plus		624
625			625
626			626
627	RUG SSC 627 = Medicaid FFS; 628 = Medicaid Hospice; 629 = STAR+Plus		627
628			628
629			629
630	RUG SSB 630 = Medicaid FFS; 631 = Medicaid Hospice; 632 = STAR+Plus		630
631			631
632			632
633	RUG SSA 633 = Medicaid FFS; 634 = Medicaid Hospice; 635 = STAR+Plus		633
634			634
635			635
636	RUG CC2 636 = Medicaid FFS; 637 = Medicaid Hospice; 638 = STAR+Plus		636
637			637
638			638
639	RUG CC1 639 = Medicaid FFS; 640 = Medicaid Hospice; 641 = STAR+Plus		639
640			640
641			641
642	RUG CB2 642 = Medicaid FFS; 643 = Medicaid Hospice; 644 = STAR+Plus		642
643			643
644			644

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 Provider Name
 Date

Contract Number
 Period Ended

Item No.	Description	Item No.	Value
645	RUG CB1 645 = Medicaid FFS; 646 = Medicaid Hospice; 647 = STAR+Plus	645	
646		646	
647		647	
648	RUG CA2 648 = Medicaid FFS; 649 = Medicaid Hospice; 650 = STAR+Plus	648	
649		649	
650		650	
651	RUG CA1 651 = Medicaid FFS; 652 = Medicaid Hospice; 653 = STAR+Plus	651	
652		652	
653		653	
654	RUG IB2 654 = Medicaid FFS; 655 = Medicaid Hospice; 656 = STAR+Plus	654	
655		655	
656		656	
657	RUG IB1 657 = Medicaid FFS; 658 = Medicaid Hospice; 659 = STAR+Plus	657	
658		658	
659		659	
660	RUG IA2 660 = Medicaid FFS; 661 = Medicaid Hospice; 662 = STAR+Plus	660	
661		661	
662		662	
663	RUG IA1 663 = Medicaid FFS; 664 = Medicaid Hospice; 665 = STAR+Plus	663	
664		664	
665		665	
666	RUG BB2 666 = Medicaid FFS; 667 = Medicaid Hospice; 668 = STAR+Plus	666	
667		667	
668		668	
669	RUG BB1 669 = Medicaid FFS; 670 = Medicaid Hospice; 671 = STAR+Plus	669	
670		670	
671		671	
672	RUG BA2 672 = Medicaid FFS; 673 = Medicaid Hospice; 674 = STAR+Plus	672	
673		673	
674		674	
675	RUG BA1 675 = Medicaid FFS; 676 = Medicaid Hospice; 677 = STAR+Plus	675	
676		676	
677		677	
678	RUG PE2 678 = Medicaid FFS; 679 = Medicaid Hospice; 680 = STAR+Plus	678	
679		679	
680		680	
681	RUG PE1 681 = Medicaid FFS; 682 = Medicaid Hospice; 683 = STAR+Plus	681	
682		682	
683		683	
684	RUG PD2 684 = Medicaid FFS; 685 = Medicaid Hospice; 686 = STAR+Plus	684	
685		685	
686		686	
687	RUG PD1 687 = Medicaid FFS; 688 = Medicaid Hospice; 689 = STAR+Plus	687	
688		688	
689		689	
690	RUG PC2 690 = Medicaid FFS; 691 = Medicaid Hospice; 692 = STAR+Plus	690	
691		691	
692		692	
693	RUG PC1 693 = Medicaid FFS; 694 = Medicaid Hospice; 695 = STAR+Plus	693	
694		694	
695		695	

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Prepared by		Contract Number	
Provider Name		Period Ended	
Date			
Item No.	Description	Item No.	Value
696	RUG PB2 696 = Medicaid FFS; 697 = Medicaid Hospice; 698 = STAR+Plus	696	
697		697	
698		698	
699	RUG PB1 699 = Medicaid FFS; 700 = Medicaid Hospice; 701= STAR+Plus	699	
700		700	
701		701	
702	RUG PA2 702 = Medicaid FFS; 703 = Medicaid Hospice; 704 = STAR+Plus	702	
703		703	
704		704	
705	RUG PA1 705 = Medicaid FFS; 706 = Medicaid Hospice; 707 = STAR+Plus	705	
706		706	
707		707	
708	RUG BC1 708 = Medicaid FFS; 709 = Medicaid Hospice; 710 = STAR+Plus	708	
709		709	
710		710	
711	RUG PCE 711 = Medicaid FFS; 712 = Medicaid Hospice; 713 = STAR+Plus	711	
712		712	
713		713	
714	TOTAL Days of Service Medicaid FFS (sum items 606, 609, 612, 615, 618, 621, 624, 627, 630, 633, 636, 639, 642, 645, 648, 651, 654, 657, 660, 663, 666, 669, 672, 675, 678, 681, 684, 687, 690, 693, 696, 699, 702, 705, 708, and 711)	714	
715	TOTAL Days of Service Medicaid Hospice (sum items 607, 610, 613, 616, 619, 622, 625, 628, 631, 634, 637, 640, 643, 646, 649, 652, 655, 658, 661, 664, 667, 670, 673, 676, 679, 682, 685, 688, 691, 694, 697, 700, 703, 706, 709, and 712)	715	
716	TOTAL Days of Service Medicaid STAR+Plus (sum items 608, 611, 614, 617, 620, 623, 626, 629, 632, 635, 638, 641, 644, 647, 650, 653, 656, 659, 662, 665, 668, 671, 674, 677, 680, 683, 686, 689, 692, 695, 698, 701, 704, 707, 710, and 713)	716	
717	TOTAL Days of Service for Medicaid in Medicaid-Contracted Beds (sum items 714, 715, and 716)	717	
718	Medicare Days of Service in Medicaid-Contracted Beds	718	
719	Other Days of Service in Medicaid-Contracted Beds	719	
720	TOTAL Days of Service in Medicaid-Contracted Beds 02/01/11 thru 08/31/11 (Sum items 717 thru 719)	720	
721	Days of Service in Non-Medicaid-Contracted Beds	721	
722	TOTAL DAYS OF SERVICE 02/01/11 thru 08/31/11 (Sum items 720 and 721)	722	
VENTILATOR SUPPLEMENTAL PAYMENTS		02/01/11 thru 08/31/11	
(include no decimals)			
For Medicaid Days of Service identified in items 606 thru 713, enter the Days of Service qualifying for supplemental payments for ventilator or pediatric tracheostomy care.			
SUPPLEMENTAL	Medicaid Days	Medicaid Days	Medicaid Days
PAYMENT TYPE	Fee for Service (FFS)	Hospice	STAR+Plus
723	Ventilator Continuous - 723 = Medicaid FFS; 724 = Medicaid Hospice; 725 = STAR+Plus	723	
724		724	
725		725	
726	Ventilator Partial - 726 = Medicaid FFS; 727 = Medicaid Hospice; 728 = STAR+Plus	726	
727		727	
728		728	

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Item No.	Description	Item No.	Value
729	Pediatric Tracheostomy 729 = Medicaid FFS; 730 = Medicaid Hospice; 731 = STAR+Plus	729	
730		730	
731		731	

DAYS OF SERVICE IN MEDICAID-CONTRACTED BEDS 09/01/11 thru 08/31/12
 (include no decimals)

This report can accommodate a date range of 23 months.

ONLY COMPLETE THE UNITS OF SERVICE LINES FOR THE REPORTING PERIOD OF THIS COST REPORT AS ENTERED IN LINE ITEMS 10 and 11.

GROUP	Medicaid Days Fee for Service (FFS)	Medicaid Days Hospice	Medicaid Days STAR+Plus	Item No.
732	RUG RAD 732 = Medicaid FFS; 733 = Medicaid Hospice; 734 = STAR+Plus			732
733				733
734				734
735	RUG RAC 735 = Medicaid FFS; 736 = Medicaid Hospice; 737 = STAR+Plus			735
736				736
737				737
738	RUG RAB 738 = Medicaid FFS; 739 = Medicaid Hospice; 740 = STAR+Plus			738
739				739
740				740
741	RUG RAA 741 = Medicaid FFS; 742 = Medicaid Hospice; 743 = STAR+Plus			741
742				742
743				743
744	RUG SE3 744 = Medicaid FFS; 745 = Medicaid Hospice; 746 = STAR+Plus			744
745				745
746				746
747	RUG SE2 747 = Medicaid FFS; 748 = Medicaid Hospice; 749 = STAR+Plus			747
748				748
749				749
750	RUG SE1 750 = Medicaid FFS; 751 = Medicaid Hospice; 752 = STAR+Plus			750
751				751
752				752
753	RUG SSC 753 = Medicaid FFS; 754 = Medicaid Hospice; 755 = STAR+Plus			753
754				754
755				755
756	RUG SSB 756 = Medicaid FFS; 757 = Medicaid Hospice; 758 = STAR+Plus			756
757				757
758				758
759	RUG SSA 759 = Medicaid FFS; 760 = Medicaid Hospice; 761 = STAR+Plus			759
760				760
761				761
762	RUG CC2 762 = Medicaid FFS; 763 = Medicaid Hospice; 764 = STAR+Plus			762
763				763
764				764
765	RUG CC1 765 = Medicaid FFS; 766 = Medicaid Hospice; 767 = STAR+Plus			765
766				766
767				767
768	RUG CB2 768 = Medicaid FFS; 769 = Medicaid Hospice; 770 = STAR+Plus			768
769				769
770				770

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Item No.	Description	Item No.	Value
771	RUG CB1 771 = Medicaid FFS; 772 = Medicaid Hospice; 773 = STAR+Plus	771	
772		772	
773		773	
774	RUG CA2 774 = Medicaid FFS; 775 = Medicaid Hospice; 776 = STAR+Plus	774	
775		775	
776		776	
777	RUG CA1 777 = Medicaid FFS; 778 = Medicaid Hospice; 779 = STAR+Plus	777	
778		778	
779		779	
780	RUG IB2 780 = Medicaid FFS; 781 = Medicaid Hospice; 782 = STAR+Plus	780	
781		781	
782		782	
783	RUG IB1 783 = Medicaid FFS; 784 = Medicaid Hospice; 785 = STAR+Plus	783	
784		784	
785		785	
786	RUG IA2 786 = Medicaid FFS; 787 = Medicaid Hospice; 788 = STAR+Plus	786	
787		787	
788		788	
789	RUG IA1 789 = Medicaid FFS; 790 = Medicaid Hospice; 791 = STAR+Plus	789	
790		790	
791		791	
792	RUG BB2 792 = Medicaid FFS; 793 = Medicaid Hospice; 794 = STAR+Plus	792	
793		793	
794		794	
795	RUG BB1 795 = Medicaid FFS; 796 = Medicaid Hospice; 797 = STAR+Plus	795	
796		796	
797		797	
798	RUG BA2 798 = Medicaid FFS; 799 = Medicaid Hospice; 800 = STAR+Plus	798	
799		799	
800		800	
801	RUG BA1 801 = Medicaid FFS; 802 = Medicaid Hospice; 803 = STAR+Plus	801	
802		802	
803		803	
804	RUG PE2 804 = Medicaid FFS; 805 = Medicaid Hospice; 806 = STAR+Plus	804	
805		805	
806		806	
807	RUG PE1 807 = Medicaid FFS; 808 = Medicaid Hospice; 809 = STAR+Plus	807	
808		808	
809		809	
810	RUG PD2 810 = Medicaid FFS; 811 = Medicaid Hospice; 812 = STAR+Plus	810	
811		811	
812		812	
813	RUG PD1 813 = Medicaid FFS; 814 = Medicaid Hospice; 815 = STAR+Plus	813	
814		814	
815		815	
816	RUG PC2 816 = Medicaid FFS; 817 = Medicaid Hospice; 818 = STAR+Plus	816	
817		817	
818		818	
819	RUG PC1 819 = Medicaid FFS; 820 = Medicaid Hospice; 821 = STAR+Plus	819	
820		820	
821		821	

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Date			
Item No.	Description	Item No.	Value
822	RUG PB2 822 = Medicaid FFS; 823 = Medicaid Hospice; 824 = STAR+Plus	822	
823		823	
824		824	
825	RUG PB1 825 = Medicaid FFS; 826 = Medicaid Hospice; 827= STAR+Plus	825	
826		826	
827		827	
828	RUG PA2 828 = Medicaid FFS; 829 = Medicaid Hospice; 830 = STAR+Plus	828	
829		829	
830		830	
831	RUG PA1 831 = Medicaid FFS; 832 = Medicaid Hospice; 833 = STAR+Plus	831	
832		832	
833		833	
834	RUG BC1 834 = Medicaid FFS; 835 = Medicaid Hospice; 836 = STAR+Plus	834	
835		835	
836		836	
837	RUG PCE 837 = Medicaid FFS; 838 = Medicaid Hospice; 839 = STAR+Plus	837	
838		838	
839		839	
840	TOTAL Days of Service Medicaid FFS (sum items 732, 735, 738, 741, 744, 747, 750, 753, 756, 759, 762, 765, 768, 771, 774, 777, 780, 783, 786, 789, 792, 795, 798, 801, 804, 807, 810, 813, 816, 819, 822, 825, 828, 831, 834, and 837)	840	
841	TOTAL Days of Service Medicaid Hospice (sum items 733, 736, 739, 742, 745, 748, 751, 754, 757, 760, 763, 766, 769, 772, 775, 778, 781, 784, 787, 790, 793, 796, 799, 802, 805, 808, 811, 814, 817, 820, 823, 826, 829, 832, 835, and 838)	841	
842	TOTAL Days of Service Medicaid STAR+Plus (sum items 734, 737, 740, 743, 746, 749, 752, 755, 758, 761, 764, 767, 770, 773, 776, 779, 782, 785, 788, 791, 794, 797, 800, 803, 806, 809, 812, 815, 818, 821, 824, 827, 830, 833, 836, and 839)	842	
843	TOTAL Days of Service for Medicaid in Medicaid-Contracted Beds (sum items 840, 841, and 842)	843	
844	Medicare Days of Service in Medicaid-Contracted Beds	844	
845	Other Days of Service in Medicaid-Contracted Beds	845	
846	TOTAL Days of Service in Medicaid-Contracted Beds 09/01/11 thru 08/31/12 (Sum items 843 thru 845)	846	
847	Days of Service in Non-Medicaid-Contracted Beds	847	
848	TOTAL DAYS OF SERVICE 09/01/11 thru 08/31/12 (Sum items 846 and 847)	848	
VENTILATOR SUPPLEMENTAL PAYMENTS		09/01/11 thru 08/31/12	
(include no decimals)			
For Medicaid Days of Service identified in items 732 thru 839, enter the Days of Service qualifying for supplemental payments for ventilator or pediatric tracheostomy care.			
SUPPLEMENTAL	Medicaid Days	Medicaid Days	Medicaid Days
PAYMENT TYPE	Fee for Service (FFS)	Hospice	STAR+Plus
849	Ventilator Continuous 849 = Medicaid Days FFS; 850 = Medicaid Hospice; 851 = STAR+Plus	849	
850		850	
851		851	
852	Ventilator Partial 852 = Medicaid Days FFS; 853 = Medicaid Hospice; 854 = STAR+Plus	852	
853		853	
854		854	

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855	Pediatric Tracheostomy 855 = Medicaid Days FFS; 856 = Medicaid Hospice; 857 = STAR+Plus	855	
856		856	
857		857	

DAYS OF SERVICE IN MEDICAID-CONTRACTED BEDS 09/01/12 thru 12/31/12
 (include no decimals)

This report can accommodate a date range of 23 months.

ONLY COMPLETE THE UNITS OF SERVICE LINES FOR THE REPORTING PERIOD OF THIS COST REPORT AS ENTERED IN LINE ITEMS 10 and 11.

GROUP	Medicaid Days Fee for Service (FFS)	Medicaid Days Hospice	Medicaid Days STAR+Plus	Item No.
858	RUG RAD 858 = Medicaid FFS; 859 = Medicaid Hospice; 860 = STAR+Plus			858
859				859
860				860
861	RUG RAC 861 = Medicaid FFS; 862 = Medicaid Hospice; 863 = STAR+Plus			861
862				862
863				863
864	RUG RAB 864 = Medicaid FFS; 865 = Medicaid Hospice; 866 = STAR+Plus			864
865				865
866				866
867	RUG RAA 867 = Medicaid FFS; 868 = Medicaid Hospice; 869 = STAR+Plus			867
868				868
869				869
870	RUG SE3 870 = Medicaid FFS; 871 = Medicaid Hospice; 872 = STAR+Plus			870
871				871
872				872
873	RUG SE2 873 = Medicaid FFS; 874 = Medicaid Hospice; 875 = STAR+Plus			873
874				874
875				875
876	RUG SE1 876 = Medicaid FFS; 877 = Medicaid Hospice; 878 = STAR+Plus			876
877				877
878				878
879	RUG SSC 879 = Medicaid FFS; 880 = Medicaid Hospice; 881 = STAR+Plus			879
880				880
881				881
882	RUG SSB 882 = Medicaid FFS; 883 = Medicaid Hospice; 884 = STAR+Plus			882
883				883
884				884
885	RUG SSA 885 = Medicaid FFS; 886 = Medicaid Hospice; 887 = STAR+Plus			885
886				886
887				887
888	RUG CC2 888 = Medicaid FFS; 889 = Medicaid Hospice; 890 = STAR+Plus			888
889				889
890				890
891	RUG CC1 891 = Medicaid FFS; 892 = Medicaid Hospice; 893 = STAR+Plus			891
892				892
893				893
894	RUG CB2 894 = Medicaid FFS; 895 = Medicaid Hospice; 896 = STAR+Plus			894
895				895
896				896

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897	RUG CB1 897 = Medicaid FFS; 898 = Medicaid Hospice; 899 = STAR+Plus	897	
898		898	
899		899	
900	RUG CA2 900 = Medicaid FFS; 901 = Medicaid Hospice; 902 = STAR+Plus	900	
901		901	
902		902	
903	RUG CA1 903 = Medicaid FFS; 904 = Medicaid Hospice; 905 = STAR+Plus	903	
904		904	
905		905	
906	RUG IB2 906 = Medicaid FFS; 907 = Medicaid Hospice; 908 = STAR+Plus	906	
907		907	
908		908	
909	RUG IB1 909 = Medicaid FFS; 910 = Medicaid Hospice; 911 = STAR+Plus	909	
910		910	
911		911	
912	RUG IA2 912 = Medicaid FFS; 913 = Medicaid Hospice; 914 = STAR+Plus	912	
913		913	
914		914	
915	RUG IA1 915 = Medicaid FFS; 916 = Medicaid Hospice; 917 = STAR+Plus	915	
916		916	
917		917	
918	RUG BB2 918 = Medicaid FFS; 919 = Medicaid Hospice; 920 = STAR+Plus	918	
919		919	
920		920	
921	RUG BB1 921 = Medicaid FFS; 922 = Medicaid Hospice; 923 = STAR+Plus	921	
922		922	
923		923	
924	RUG BA2 924 = Medicaid FFS; 925 = Medicaid Hospice; 926 = STAR+Plus	924	
925		925	
926		926	
927	RUG BA1 927 = Medicaid FFS; 928 = Medicaid Hospice; 929 = STAR+Plus	927	
928		928	
929		929	
930	RUG PE2 930 = Medicaid FFS; 931 = Medicaid Hospice; 932 = STAR+Plus	930	
931		931	
932		932	
933	RUG PE1 933 = Medicaid FFS; 934 = Medicaid Hospice; 935 = STAR+Plus	933	
934		934	
935		935	
936	RUG PD2 936 = Medicaid FFS; 937 = Medicaid Hospice; 938 = STAR+Plus	936	
937		937	
938		938	
939	RUG PD1 939 = Medicaid FFS; 940 = Medicaid Hospice; 941 = STAR+Plus	939	
940		940	
941		941	
942	RUG PC2 942 = Medicaid FFS; 943 = Medicaid Hospice; 944 = STAR+Plus	942	
943		943	
944		944	
945	RUG PC1 945 = Medicaid FFS; 946 = Medicaid Hospice; 947 = STAR+Plus	945	
946		946	
947		947	

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Item No.	Description	Item No.	Value
948	RUG PB2 948 = Medicaid FFS; 949 = Medicaid Hospice; 950 = STAR+Plus	948	
949		949	
950		950	
951	RUG PB1 951 = Medicaid FFS; 952 = Medicaid Hospice; 953 = STAR+Plus	951	
952		952	
953		953	
954	RUG PA2 954 = Medicaid FFS; 955 = Medicaid Hospice; 956 = STAR+Plus	954	
955		955	
956		956	
957	RUG PA1 957 = Medicaid FFS; 958 = Medicaid Hospice; 959 = STAR+Plus	957	
958		958	
959		959	
960	RUG BC1 960 = Medicaid FFS; 961 = Medicaid Hospice; 962 = STAR+Plus	960	
961		961	
962		962	
963	RUG PCE 963 = Medicaid FFS; 964 = Medicaid Hospice; 965 = STAR+Plus	963	
964		964	
965		965	
966	TOTAL Days of Service Medicaid FFS (sum items 858, 861, 864, 867, 870, 873, 876, 879, 882, 885, 888, 891, 894, 897, 900, 903, 906, 909, 912, 915, 918, 921, 924, 927, 930, 933, 936, 939, 942, 945, 948, 951, 954, 957, 960, and 963)	966	
967	TOTAL Days of Service Medicaid Hospice (sum items 859, 862, 865, 868, 871, 874, 877, 880, 883, 886, 889, 892, 895, 898, 901, 904, 907, 910, 913, 916, 919, 922, 925, 928, 931, 934, 937, 940, 943, 946, 949, 952, 955, 958, 961, and 964)	967	
968	TOTAL Days of Service Medicaid STAR+Plus (sum items 860, 863, 866, 869, 872, 875, 878, 881, 884, 887, 890, 893, 896, 899, 902, 905, 908, 911, 914, 917, 920, 923, 926, 929, 932, 935, 938, 941, 944, 947, 950, 953, 956, 959, 962, and 965)	968	
969	TOTAL Days of Service for Medicaid in Medicaid-Contracted Beds (sum items 966, 967, and 968)	969	
970	Medicare Days of Service in Medicaid-Contracted Beds	970	
971	Other Days of Service in Medicaid-Contracted Beds	971	
972	TOTAL Days of Service in Medicaid-Contracted Beds - 09/01/12 thru 12/31/12 (Sum items 969 thru 971)	972	
973	Days of Service in Non-Medicaid-Contracted Beds	973	
974	TOTAL DAYS OF SERVICE - 09/01/12 thru 12/31/12 (Sum items 972 and 973)	974	
VENTILATOR SUPPLEMENTAL PAYMENTS		09/01/12 thru 12/31/12	
(include no decimals)			
For Medicaid Days of Service identified in items 858 thru 965, enter the Days of Service qualifying for supplemental payments for ventilator or pediatric tracheostomy care.			
SUPPLEMENTAL	Medicaid Days	Medicaid Days	Medicaid Days
PAYMENT TYPE	Fee For Service (FFS)	Hospice	STAR+Plus
975	Ventilator Continuous 975 = Medicaid FFS; 976 = Medicaid Hospice; 977 = STAR+Plus	975	
976		976	
977		977	
978	Ventilator Partial 978 = Medicaid FFS; 979 = Medicaid Hospice; 980 = STAR+Plus	978	
979		979	
980		980	

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Item No.	Description	Item No.	Value
981	Pediatric Tracheostomy 981 = Medicaid FFS; 982 = Medicaid Hospice; 983 = STAR+Plus	981	
982		982	
983		983	