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State/Territory Name: KS

State Plan Amendment (SPA) #: 16-0013

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAY 23 2017

Michael Randol, Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

RE: Kansas State Plan Amendment TN: 16-013

Dear Mr. Randol:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 16-013. This amendment provides for a 4.00% reduction in psychiatric residential treatment facility (PRTF) payment rates. This SPA also updates the PRTF cost report that is included as an attachment in the State plan.

As part of our review of the pending SPA, we requested the State to demonstrate that the payment rate decrease would not restrict access to services for the fee-for-service population in the Kansas Medicaid program. The State provided data confirming that 97% of Medicaid beneficiaries in Kansas receive care through a managed care arrangement and that the 3% remaining in the fee-for-service system includes individuals that receive limited specialty services or services in periods of presumptive or retro-active eligibility. Based on this information, the state concluded that access will not be affected by the rate reductions under SPA 16-013. The State must continue to monitor access to care for the fee-for-service population and promptly notify us if access to care appears to be lessening.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 16-013 is approved effective July 1, 2016. We are enclosing the CMS-179 and the amended plan pages.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: KS 16-013

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 441-151

7. FEDERAL BUDGET IMPACT
a. FFY 2016 ($ 51)
b. FFY 2017 ($207)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19-A, Page 38, 40, 43 & 44
Attachment 1 to Attachment 4.19-A, Pages 1-7
Attachment 1 to Attachment 4.19-A, Pages 10-19
Attachment 1 to Attachment 4.19-A, KDADS PRTF-01, Pages 1-12
Attachment 2 to Attachment 4.19-A, Pages 1-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*

Attachment 4.19-A, Page 38, 40, 43 & 44
Attachment 1 to Attachment 4.19-A, Pages 1-7
Attachment 1 to Attachment 4.19-A, Pages 10-19
Attachment 1 to Attachment 4.19-A, KDADS PRTF-01, Pages 1-12
Attachment 2 to Attachment 4.19-A, Pages 1-4

10. SUBJECT OF AMENDMENT
Psychiatric Residential Treatment Facilities (PRTFs) Payment Reduction

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Michal Randol is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
for Michael Randol

14. TITLE
Director, Division of Health Care Finance

15. DATE SUBMITTED
September 21, 2016

16. RETURN TO
Michael Randol, Director
KDHE, Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED MAY 23 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME Kristin FAN

22. TITLE Director, FMCO

23. REMARKS

FORM CMS-179 (07/92

Instructions on Back

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

Under the Medicaid program, the State of Kansas pays psychiatric residential treatment facilities (PRTFs) for care and treatment provided to residents who are eligible for Medicaid benefits. The Kansas Department of Aging and Disability Services (the Department) administers the PRTF program pursuant to an interagency agreement with the Kansas Department of Health and Environment, Division of Health Care Finance, the single state Medicaid agency.

There are two classes of PRTFs:

I. Class I is a PRTF that meets all:
   A. Requirements for Medicaid participation as specified in 42 CFR 441.151, and
   B. State standards and licensing requirements for a Class I PRTF including:
      1) Accreditation by the Joint Commission,
      2) Being licensed, but not Medicaid certified, as a psychiatric hospital, and
      3) Not refusing to admit any otherwise qualified Medicaid beneficiary who has a documented need for residential inpatient psychiatric treatment.
II. Class II is a PRTF that meets all:
   A. Requirements for Medicaid participation as specified in 42 CFR 441.151, and
   B. State standards and licensing requirements of a Class II PRTF.

The narrative explanation of the reimbursement formula for each class of PRTF is divided into three major sections: Historical Costs, Rate Calculations, and Payment Limits.

Narrative Explanation of Reimbursement Formula for Class I PRTF

1) Historical Cost

Cost Reports

Providers are required to submit information on all costs incurred during the fiscal period from July 1st through June 30th on a uniform cost report, the PRTF Financial and Statistical Report. It organizes the commonly incurred business expenses of PRTFs into five reimbursable cost centers (Administration; Facility Operating; Property; Room, Board, and Support; and Treatment) and one non-reimbursable/non-resident related cost center. Reporting of non-reimbursable/non-resident related costs allows total operating expenses to be reconciled to the PRTFs' accounting records. Cost reports are to be submitted by September 30th

The cost report and cost report instructions are provided in Attachment 1.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities
Narrative Explanation of Reimbursement Formula

Department will make appropriate adjustments and allowances to account for staffing ratios and unique physical plant requirements needed to serve children and adolescents who have a higher acuity of mental illness compared with those served by other PRTFs. The approved initial rates will be paid until new rates can be established from a complete full year cost report period using the rate calculation methods described below. Once a new rate is established from a full year cost report period, a retrospective cost settlement will be made from the first day of operation of the new Class I PRTF to the date that the new prospective rate is set.

2) Rate Calculations

Reimbursement rates will be calculated for the payment rate period of January 1st through December 31st, with a mid period adjustment to the Treatment cost center effective for the payment rate period from July 1st through December 31st.

Inflation

Inflation will be applied to all allowable reported costs except:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

Inflation will be applied from the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket without Capital Index (IHS Index).

The IHS Indices listed in the latest available quarterly publication will be used to develop the inflation tables used for all payment schedules processed during the payment rate period. This may require the use of forecasted data. The inflation tables will not be revised until the next payment rate period.

Per Diem Costs

Per diem costs are determined by dividing each PRTF's inflated allowable costs, for each cost center, by the total number of reported resident bed days. Total PRTF reimbursement will include the actual allowed inflated per diem costs for each of the Administration; Facility Operating; Property; Room, Board, and Support; and Treatment cost centers.

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

report or mid-period report in conformance with the schedule described above. The new operator or owner is responsible for obtaining historical cost information from the prior operator for the months needed to submit accurate and complete reports that includes costs incurred when the new operator was not involved in running the PRTF. The cost report information from the old and new operators shall be combined to prepare a 12-month cost report or a 6-month mid-period report in conformance to the schedule described above.

When an arms length change in provider takes place, the new owner assumes the reimbursement rate of the old owner until the new owner can submit a full year or mid-period cost report in conformance with the schedule described above.

New Provider

The per diem rate for a new PRTF will be the total of the state-wide median of each cost centers calculated at the last full year cost report until the new PRTF can report a full year cost report in conformance with the schedule described above.

2) Rate Calculations

Reimbursement rates will be calculated for the payment rate period of January 1st through December 31st, with a mid period adjustment to the Treatment cost center effective for the payment rate period from July 1st through December 31st.

Inflation

Inflation will be applied to all allowable reported costs except:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

Inflation will be applied from the midpoint of each cost report period to the midpoint of the rate payment period. The inflation will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket without Capital Index (IHS Index).

Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Narrative Explanation of Reimbursement Formula

The IHS Indices listed in the latest available quarterly publication will be used to develop the inflation tables used for all payment schedules processed during the payment rate period. This may require the use of forecasted data. The inflation tables will not be revised until the next payment rate period.

Per Diem Costs

Per diem costs are determined by dividing each PRTF's inflated allowable costs, for each cost center, by the total number of reported resident bed days. Total PRTF reimbursement will include the actual allowed inflated per diem costs for each of the cost centers for Administration; Facility Operating; Property; and Room, Board, and Support or the upper payment limit for each of these cost centers, whichever is less, plus the actual allowable inflated per diem for the Treatment cost center.

Mid-Period Rate Adjustment

The Treatment cost center will be adjusted for the difference between the inflated allowable per diem costs calculated for the full year rate payment period and the inflated allowable per diem costs calculated for the mid-period adjustment. This difference will be added to the rate currently in effect on July 1 and will be paid through the end of the rate payment period, December 31.

Attachment 1 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

State of Kansas
Department for Aging and Disability Services (KDADS)

INSTRUCTIONS FOR COMPLETING THE PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY FINANCIAL AND STATISTICAL REPORT (Cost Report - FORM KDADS-PRTF-01)

PURPOSE

The purpose of this report is to obtain the resident-related costs incurred by psychiatric residential treatment facilities (PRTF) in providing services according to applicable state and federal laws, and quality and safety standards.

SUBMITTAL INSTRUCTIONS

Blank KDADS-PRTF-01(Financial and Statistical Report) and KDADS-PRTF-09 (Census) forms can be requested from the Facilities Reimbursement Manager at costreports@ks.gov.

Send the completed form KDADS-PRTF-01 and form KDADS-PRTF-09 (applicable to the reporting period) for each month of the reporting period, along with a signed copy of the declaration page of the KDADS-PRTF-01 to costreports@ks.gov. If sent on CD-Rom or flashdrive, send to the following address:

Kansas Department for Aging and Disability Services
Attn: Facilities Reimbursement Manager
503 Kansas Avenue
Topeka, KS 66603

All inquires on completion of these forms should be directed to the KDADS Facilities Reimbursement Manger at (785) 296-4986.

GENERAL

The cost report is organized by the following sections. Not all expense lines are within each section. A separate cost report must be completed for each PRTF.

General Information
Schedule A, Facility Administrative Cost Center
Schedule A, Treatment Facility Operating Cost Center
Schedule A, Facility Property Cost Center
Schedule A, Room, Board, and Support Cost Center
Schedule A, Treatment Cost Center
Schedule A, Non-Reimbursable/Non-Resident Related Expense Items
Schedule B, Expense Reconciliation
Schedule C, Statement of Owners and Related Parties
Schedule D, Statement Related to Interest on All Bonds, Loans, Notes and Mortgages Payable
Schedule E, Revenue Statement
Schedule F, Fixed Asset, Depreciation & Amortization Questionnaire
Declaration of Preparer and Declaration of Owner, Partner, or Office of Corporation

1. Complete the forms accurately and legibly. Any report that is incomplete or is not legible shall be promptly returned to the provider. Failure to submit a complete cost report shall result in penalties as described in #8.

Attachment 1 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

2. **All amounts must be rounded to the nearest dollar, prior to cost report entry.**

3. **DO NOT** add lines to the forms. Use "OTHER" lines for resident-related expenses not designated on the Expense Statement, Schedule A. Attach a schedule if necessary.

4. **DO NOT** cross out or re-title lines on the forms. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation. The attachment should be **sorted by cost report expense lines** and should include subtotals.

5. Use the accrual method of accounting in reporting financial data. Revenues are reported in the period when **earned**, and not when received, and expenses are reported when **incurred**.

6. Estimates of revenues and expenses are not acceptable.

7. A twelve month Cost Report for all costs incurred during the state's fiscal year, July 1st through June 30th, must be submitted by September 30th. A mid-period cost report for costs incurred July 1st through December 31st must be submitted by March 31st.

8. The provider may request a one-month extension of the due date by submitting the request, in writing to the address in the submittal instructions, within the time period allowed for filing the original cost report.

   A one-month extension of the due date for the filing of a cost report may be granted by the agency when the cause for delay is beyond the control of the provider. Delays beyond the control of the provider that may be considered by the agency in granting an extension shall include:

   a. disasters that significantly impair the routine operations of the facility or business
   b. destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonable foreseeable
   c. computer viruses that impair the accurate completion of cost report information

   The provider shall make the request in writing and it shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

   The extension will be granted if the agency determines that the provider has shown good cause.

   NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES.

   Each provider filing a cost report after the due date shall(may) be subject to the following penalties:

   a. All further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.
   b. Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program

9. Each PRTF must maintain adequate accounting and/or statistical records. Inadequate record keeping is cause for suspension of payments. If PRTF program expenses have been co-mingled with the

non-PRTF expenses, see the instructions for provider adjustments on Schedule A, Expense Schedule.

10. Copies of the State Medicaid Plan, the Cost Report form and related instructions governing PRTF reimbursement may be obtained from the web site. NOTE: SINCE THE COST REPORT INSTRUCTIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM KDADS-PRTF-01 FOR SUBMISSION.

Definitions

1. Accrediting agency – Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation of Service for Families and Children, or the Commission on Accreditation of Rehabilitation Facilities.

2. Adequate financial cost data – Cost data shall be in accordance with state and federal Medicaid requirements and general accounting rules and based on the accrual basis of accounting. Estimates of costs are not be allowable.

3. Central Office – A central office is an expense center that provides administrative support to more than one program or service unit including the PRTF.

4. Cost and other accounting information – adequate financial data about the PRTF operation, including source documentation, that is accurate, current, and sufficiently detailed to accomplish the purposes for which it is intended. Source documentation, including petty cash payout memoranda and original invoices, shall be valid only if the documentation originated at the time and near the place of the transaction. In order to provide the required cost data, the provider shall maintain financial and statistical records in a manner that is consistent from one period to another. This requirement shall not preclude a beneficial change in accounting procedures when there is a compelling reason to effect a change of procedures.

5. Costs not related to resident care – means costs that are not appropriate, necessary, or proper in developing and maintaining the PRTF operation and activities. These costs shall not be allowed in computing reimbursable costs.

6. Costs related to resident care – necessary and proper costs, arising from arm's-length transactions in accordance with general accounting rules, that are appropriate and helpful in developing and maintaining the operation of resident care facilities and activities.

7. Fiscal Year – The state fiscal year of July 1 through June 30 shall be the fiscal year for the cost report.

8. Mid-Period – July 1 through December 31.

9. Non-working owners – any individual or organization having five percent or more interest in the provider who does not perform a resident-related function for the PRTF.

10. Non-working related party of director – any related as defined in these definitions, who does not perform a resident-related function for the PRTF.

11. Owner – the person or legal entity that has the rights and interest of the real and personal property used to

Attachment 1 to Instructions Regarding
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provide the PRTF services.

12. Related parties – two or more parties with a relationship in which one party has the ability to influence another party to the transaction in the following manner:

    a. when one or more of the transacting parties might fail to pursue the party's or parties' own separate interest fully;
    b. when the transaction is designed to inflate the Kansas medical assistance program costs; or
    c. when any party considered a related party to a previous owner or operator becomes the employee, or otherwise functions in any capacity on behalf of a subsequent owner or operator. Related parties shall include parties related by family, business, or financial association or by common ownership or control. Transactions between related parties shall not be considered to have arisen through arm's-length negotiations.

13. Reimbursable Day – A resident must be present at 11:59 pm to receive payment for that day. If the resident is not there at 11:59 pm the resident cannot be counted as present and the PRTF cannot bill for that day unless the resident is on approved absent days. Approved absent days is defined as follows:

    Visitation days when indicated in the resident's treatment plan (within the total number of days approved for the resident's stay). The PRTF can bill for a maximum of 7 days per visit. The frequency, duration, and location of the visits must be a part of the resident's individual case plan developed by the facility prior to the visitation. An approved visitation plan must be documented in the resident's official record at the facility.

    If a resident is absent from the facility for a short time due to circumstances needing the resident's immediate attention (deaths, weddings, personal business), or the resident leaves the facility without permission, the facility can bill up to five days unless the resident's placement is terminated sooner.

14. Routine services and supplies – services and supplies that are commonly stocked for use by or provided to any resident. The services and supplies may include, but not be limited to the following:

    a. Facial tissues & toilet paper
    b. First-aid ointments and similar ointments
    c. Gloves, rubber or plastic
    d. Ice bags and hot water bottles
    e. Laundry, including personal laundry
    f. Laxatives
    g. Lotions, creams, and powders, including baby lotion, oil and powders
    h. Mouthwash, shampoo,
    i. Over-the-counter vitamins
    j. Over-the-counter analgesics and antacids taken for the occasional relief of pain or discomfort
    k. Skin antiseptics, including alcohol
    l. Thermometers
    m. All over-the-counter drugs, supplies and personal comfort items that are available without a prescription at a commercial pharmacy or medical supply outlet and are provided by the PRTF as a reasonable accommodation for individual needs and preferences.

15. Sale-leaseback – A transaction in which an owner sells a facility to a related or non-related purchaser and then leases the facility from the new owner to operate as the provider.

Attachment 1 to Instructions Regarding
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16. Working trial balance – A list of the account balances in the general ledger order that was used in completing the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance. Expenses shall reconcile to column 2 of cost report schedule A and revenues shall reconcile to column 1 of cost report Schedule E. A schedule that lists all general ledger accounts grouped by cost center and line description shall be attached.

Attachment 1 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

COST REPORT INSTRUCTIONS

COVER PAGE

Complete all provider information on the cover page.

Report the current private pay rate.

Check the type of business organization which most accurately describes your provider status or explain on the line labeled Other. Limited Liability Companies should check the box that matches their declaration for tax purposes. Please check only one.

PRTF Beds:

Lines A - E: The number of beds available multiplied by the calendar days in the reporting period = Total Bed Days Available during reporting period.

Enter beginning and ending dates, the number of beds available and the number of calendar days covered by the beginning and ending dates. The beds available multiplied by the number of calendar days = bed days at this bed count. If a change in the number of beds has occurred during the reporting period, show the increase or decrease on a separate line, the date of the change, the new bed count, and the bed days at that count.

Line F: Total days during the reporting period = column total of # of Calendar Days. This should equal 365.

Line G: Total Beds available during reporting period = column total of Bed Days @ this Bed Count

Example of Bed Days calculation:
Assume a home of 20 beds was increased on March 16 to 25 beds, the number of bed days for the period would be determined as follows:

July 1 to March 15 - 258 days x 20 beds =	5,160 bed days
March 16 to June 30 - 107 days x 25 beds =	2,675 bed days
	7,835 bed days for fiscal year

NOTE: Lines H, I and J should match totals on census form KDADS-PRTF-09.

Line H: Enter the number of Medicaid Reimbursable Days, excluding Absent Days (See definitions)

Line I: Enter the number of Medicaid Reimbursable Absent Days = (See definitions)

Line J: Enter the number of "Other Funded" Days Reimbursed = (Reimbursed = days during reporting period that beds were filled and payment source is not Medicaid)

Line K: Total Days Beds were Reimbursed = total of line H, I & J

Line L: Total Vacancy = 100% less (Total Days Beds Reimbursed/Total Beds Available)

Attachment 1 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

SCHEDULE A - EXPENSE STATEMENT

A copy of the working trial balance used to prepare the cost report must accompany the filed cost report.

All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Facility Administrative cost center. Therefore, the expense for telephone lines to the treatment units' station shall **not** be reported in the Treatment cost center. See specific line instructions for more detail. **DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.**

Total Annual Hours Paid - Column 1 - Enter the total hours paid to the employees on each of the salary lines for the reporting period. For any employee whose time is divided across multiple work functions within a facility and performs for less than a full-time-equivalent work week, defined as 40 hours per week, the work time and compensation shall be prorated on each function within a facility or within all facilities, but shall not exceed 100 percent of that person's total work time.

Per Working Trial Balance (Books) or Federal Tax Return (if un-audited) - Column 2 - Report the expenses reflected in the accounting records under the appropriate cost center (i.e., Facility Administrative, Treatment Facility Operating, Facility Property, Room, Board and Support, Treatment, and Non-reimbursable and Non-resident Related). The total of all the expense lines (Column 2) shall reconcile to the accounting records or income tax return. (For exceptions, see instructions for Schedule B.)

Provider Adjustments - Column 3 - Enter the necessary adjustments to the expenses reported in Column 2 that are not resident-related, or offset expense recoveries reported in the Revenue Statement, Schedule E Reclassification, or allocation of Column 2 expenses between cost centers or expense line items shall also be entered into Column 3. Increases shall be entered as positive amounts and decreases as negative amounts. Schedules supporting the adjustments and reclassifications must accompany the cost report.

PRTF Related Expense - Column 4 - The cost report automatically calculates the differences between Column 2 and Column 3.

State Adjustments/Adjusted Resident Related Expenses - Columns 5 & 6 - Leave blank - FOR AGENCY USE ONLY

Expense Lines

The specific instructions do not cover each line item of the expense statement. They are designed to cover items that may require additional explanation or examples.

Accounting and Data Processing - Report accounting expense on this line, except fees paid to owner/related party firms or individuals which must be reported on the owners compensation. Data processing expense related to financial management (i.e., accounting, payroll, budgeting, etc.) shall be reported on this line.

Advertising & Recruitment- Report allowable advertising and recruitment expense on this line. This line shall be used for fees paid to employment agencies, employment advertisements and ads in telephone directories. Fund raising, public relations, advertising for resident utilization and sponsorships are **not allowable** and shall be reported in the Non-reimbursable & Non-resident Related expense section of Schedule A.

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Youth Psychiatric Residential
Behavior Severity Index

Kansas Department for Aging and Disability Services
August 9, 2016

TN-MS #16-013 Approval Date MAY 23 2017 Effective Date: July 1, 2016 Supersedes TN-MS#06-09

Attachment 2 to Instructions Regarding Methods and Standards for Establishing Payment Rates Psychiatric Residential Treatment Facilities

Instructions:
The Kansas Youth Psychiatric Residential Behavior Severity Index is an instrument use to record the extent to which a youth's behavior which results from a serious emotional disturbance will increase the utilization of resources required to manage that behavior. The tool is not intended to reflect causes or the dynamics underlying the youth's serious emotional disturbance but rather is intended to provide the degree to which the youth's behavior at present or in the recent past is disruptive to functioning.

This assessment should be completed immediately prior to admission to a Psychiatric Residential Treatment Facility (PRTF) by a person who is knowledgeable about the severity of the youth's present and recent behavior. The assessment will be the utilized throughout the youth's stay in the PRTF to determine the facility's acuity index. Completed assessments will be submitted to Kansas Department for Aging and Disability Services or its designee for entry into the PRTF data base. The information in the assessment data base will be used to determine the quarterly acuity adjustment for each PRTF as specified in the state plan. In addition, the PRFT will provide assessment information upon each youth's discharge.

Assessment:
Unless otherwise instructed, for each question rate the behavior of the youth based on the degree of severity of the behavior and the frequency the behavior occurs. When scoring for the severity of a behavior use the following guidelines unless otherwise defined:

Behavior is not a problem: If the behavior is not considered a problem for the youth or those around him/her or if the behavior does not occur, mark zero in both seriousness and frequency.
Behavior presents minimal slight problem: Causes some minor challenges to the youth's life, but is manageable using typical mild interventions or redirection.
Behavior presents moderate problem: Causes significant problems in the youth's life and prevents him/her from living independently and effectively interacting with others, but is manageable using targeted, planned interventions.
Behavior presents a serious problem: Causes bodily harm to the youth or others or serious but repairable property damage. The behavior must be managed using intensive planned interventions and treatment.
Behavior presents an extremely serious problem: Behavior, if left to occur without intervention, could cause death or irreparable property damage and is only managed with intensive staff supervision using planned interventions and treatment.

General Guidelines:

1. There are four subscales which are comprised of 17 questions within the assessment: Severity of Psychiatric Symptoms, Risk Factors, Complicating Factors, and Co-Morbidity. All subscales and all questions within those subscales are to be completed. If a subscale or question is not applicable, place a 0 as the score.
2. Use a literal approach to judging behavior. Use only the definitions provided for the behavior and assess only on factual information that is available to determine if the behavior manifested. Do not infer that a behavior has occurred based on another behavior or on the youth's diagnosis. As much as possible base the ratings on what you have observed or what has been reported by other informants.

Scoring:
Scoring begins on page 13. When scoring, use the scores from the right hand box of the assessment. The four subscales have been numbered with Roman numeral's. The scoring page has been broken out by subscales. You will fill in the scores according to the directions to receive a raw score which is placed in the right hand box for each subscale. The Risk Factors Subscale has been weighted which will result in a higher score for these questions. You will add the weighted scores in this subscale in the same manner as above to receive a raw score.

When all raw scores have been tabulated the final box will be completed. The first step is to add the multiplying factors to the raw score from Subscale III: Risk Factors. You will take the risk factor raw score found in the right had box under subscale III and multiple it by the cognitive functioning score (question 17) found in the Subscale Box V: Co-Morbidity. This will give you an adjusted raw score for Subscale III. Add this total score to the raw scores found in the right hand box for subscales II, IV, and V. The result is the total score for the youth which is recorded in the right hand box at the bottom of page 14.

Attachment 2 to Instructions Regarding
Methods and Standards for Establishing Payment Rates
Psychiatric Residential Treatment Facilities

Youth Psychiatric Residential
Behavior Severity Index
2016

SECTION I. IDENTIFICATION INFORMATION:

Youth's Name:_____ **Social Security #:**_____ **Sex:**___**DOB:** ___/_____/_____
Mo. Day Yr.

Address:_____
(Street and Apartment #) (City) (State) (Zip)

Name of Guardian:_____ **Address:**_____

Guardian's Phone #: (___)_____**Relationship** (check one)**: Parent**___ **Self** ___ **SRS** ___ **JJA** ___

Race or Ethnic Group: #1 to #6 _____

1 = Asian/Asian American/Pacific Islander **2** = Black/African American
3 = First Nations/Native American/American Indian or Alaskan Native **4** = Hispanic/Latino/Mexican American
5 = White/Caucasian/European American **6** = Multiple Race/Ethnicity or Bi-Racial

Diagnosis:
Axis I _____
Axis II _____
Axis III _____
Axis IV _____
Axis V _____ **GAF:** _____

Prognosis: _____

Other Medically Intense Needs that would complicate treatment:_____

Name of Assessing Individual (include Qualifications):_____

CMHC / Facility: _____ **Phone #:** (___)_____

Initial Assessment Date (Mo/Day/Yr): __/__/__ **Discharge Assessment Date (Mo/Day/Yr):** __/__/__

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SECTION II. Severity of Psychiatric Symptoms:

1. Neuropsychiatric Disturbance. This dimension is used to rate symptoms of psychiatric disorders with a known neurological base. DSM-IV disorders included on this dimension are Schizophrenia, Psychotic disorders (unipolar, bipolar, NOS), Autism, and some encephalopathies. The common symptoms of these disorders include hallucinations, delusions, unusual thought processes, strange speech, and bizarre/idiosyncratic behavior.

Score 1: _____

0 This youth has no evidence of thought disturbances. Both thought processes and content are within normal range.

1 This youth has evidence of mild disruption in thought processes or content. The youth may be somewhat tangential in speech or evidence somewhat illogical thinking (age inappropriate). This level also includes youth with a history of hallucinations but none currently. This category would be used for youth who are sub-threshold for one of the DSM diagnoses listed above.

2 This youth has evidence of notable disturbance in thought process or content. The youth may be somewhat delusional or have brief or intermittent hallucinations. The youth's speech may be, at times, quite tangential or illogical. This level would be used for youth who meet the diagnostic criteria for one of the disorders listed above.

3 This youth has a severe thought disorder. The youth frequently experiences symptoms of psychosis and frequently has no reality assessment. There is evidence of ongoing delusions or hallucinations or both. The youth may be experiencing command hallucinations. This level is used for extreme cases of the diagnoses listed above.

2. Emotional Disturbance. This dimension is used to rate symptoms of the follow psychiatric disorders as specified in DSM-IV: Depression (unipolar, dysthymia, NOS), Bipolar, Intermittent Explosive Disorder, Generalized Anxiety, Eating Disorders, and Phobias. Symptoms included in this dimension are depressed mood, social withdrawal, anxious mood, sleep disturbances, weight/eating disturbances, and loss of motivation.

Score 2: _____

0 This youth has no emotional problems. No evidence of depression or anxiety.

1 This youth has mild to moderate emotional problems. Brief duration of depression, irritability, or impairment of peer, family, or academic functioning that does not lead to gross avoidance behavior. This level is used to rate either a mild phobia or anxiety problem or a sub-threshold level of symptoms for the other listed disorders.

2 This youth has a moderate to severe level of emotional disturbance. This could include major conversion symptoms, frequent anxiety attacks, obsessive rituals, flashbacks, hypervigilance, depression, or school avoidance. The youth has a diagnosis of anxiety or depression regardless of severity. This youth meets the criteria for an affective disorder listed above.

3 This youth has a very severe level of emotional disturbance. The youth stays at home or in bed all day due to anxiety or depression or one whose emotional symptoms prevent any participation in school, friendship groups, or family life. More severe forms of anxiety or depressive diagnoses would be coded here (e.g., meeting criteria in excess of the diagnosis). This youth has an extreme case of one of the disorders listed above.

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1. Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported.

Food - Report all food costs. The provider shall be required to keep records on the total number of meals served to residents, employees, guests, and outside programs. If the food expense for the employees, guests, and outside programs is included in the KDADS-PRTF-01 expenses, the expense should be offset against the dietary cost center as follows:

1. Dietary Salaries
   a. Dietary Portion Employee Benefits
   b. Dietary Owner/Related Party Compensation
   c. Dietary Consultant
   d. Food
   e. Dietary Supplies
   f. Other
   g. Total Dietary Cost ÷ Total Number of Meals Served = Cost Per Meal

2. Cost per meal x number of meals served to employees, guests, and outside programs = amount of offset

3. The cost of free employee meals shall be allocated and reported on employee benefit lines. If employees pay less than the cost for a meal, the difference between the meal revenue and cost may be reported as an employee benefit.

Insurance - Liability - Report liability insurance expense on this line.

Insurance – Other - Report insurance expense on this line. Workers' compensation and employee health and life insurance expense shall be reported on employee benefit lines. Facility insurance should be reported in the Treatment Facility Operating cost center. Insurance premiums on lives of owners and related parties are not an allowable expense, and shall be in the Non-reimbursable & Non-resident Related expense section of Schedule A.

Interest - Report the interest expense related to operating loans. Interest on loans for real and personal property and equipment shall be reported in Property cost center. The interest expense shall be incurred on indebtedness established with either of the following:

1. Lenders or lending organizations not related to the borrower; or

2. Partners, stockholders, home office organizations, or related parties, if the following conditions are met:
   a. The terms and conditions of payment of the loans shall resemble terms and conditions of an arm's-length transaction by a prudent borrower with a recognized, local lending institution with the capability of entering into a transaction of the required magnitude. A signed promissory note and loan amortization schedule shall be submitted with the cost report. Allowable interest expense shall be limited to the annual expense submitted on the loan amortization schedule, unless the loan principal is retired before the end of the amortization period.
   b. The provider shall demonstrate, to the satisfaction of KDADS, a primary business purpose for the loan other than increasing the per diem rate.
   c. The transaction shall be recognized and reported by all parties for federal income tax purposes.

3. When the general fund of a PRTF "borrows" from a donor-restricted fund, this interest expense shall

be an allowable cost. In addition, if a PRTF operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

4. The interest expense shall be reduced by the investment income from restricted or unrestricted idle funds or funded reserve accounts, except when that income is from gifts and grants, whether restricted or unrestricted, that are held in a separate account and not commingled with other funds. Income from the provider's qualified pension fund shall not be used to reduce interest expense.

5. Interest earned on restricted or unrestricted reserve accounts of industrial revenue bonds or sinking fund accounts shall be offset against interest expense and limited to the interest expense on the related debt.

6. Loans made to finance that portion of the cost of acquisition of a facility that exceeds historical cost or the cost basis recognized for program purposes shall not be considered to be reasonably related to resident care.

Interest on Equipment – Report all interest expense incurred for the acquisition of equipment and furnishings.

Interest on Real Estate - Report all interest expense incurred for the acquisition or construction of real estate. Describe fully on Schedule D. Include amortization expense for loan costs. The interest for equipment and furnishings purchased along with the building shall be reported on a separate line.

Legal - Report allowable routine legal costs and other costs associated with litigation, if the litigation is decided in the provider's favor, on this line. Costs related to resolving contested issues of title or disputes arising from the performance of contracts or agreements related to the purchase or sale of property or business is not allowable. Allowable fees paid to owner/related party firms or individuals must be reported as owner/related party compensation. Retainer fees and cost associated with claims against the state are not allowed.

Licenses, accreditation and dues - Report allowable licenses, accreditation fees and dues on this expense line. Costs of social, fraternal, civic and other organizations that concern themselves with activities unrelated to their members' professional or business activities are not allowable. Personal automobile club memberships are not allowable unless reported as compensation. Any dues paid for the cost of lobbying are not allowable. Cost of licenses for professional direct services staff is to be included in treatment cost center or the cost of licenses for facility maintenance staff is to be included in the treatment facility cost center.

Linen and Bedding Material - Report linen and bedding material expenses on this line.

Maintenance & Repairs - Report all maintenance and repair expenses for equipment and vehicle as related to administrative operating expenses in the Facility Administrative cost center, expenses applicable to the building and grounds in the Treatment Facility Operating cost center, and expenses applicable to equipment related to Room, Board and Support in the respective cost center. Vehicle maintenance and repairs expenses related to Resident Transportation should be included in the Resident Transportation line of the Treatment cost center.

Management Consultant Fees (Also, see Consultants) - Report fees paid to non-related party management consultants. If the management services company is owned or controlled by the company or person(s) that own or control the facility, actual cost of the management services company must be reported as central office costs and/or owner's compensation. See instructions for reporting central office costs.

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Consulting fees paid to owners and related parties are considered owner's compensation subject to the owner-administrator compensation limit. These fees should be reported on the Owners and Related Party Compensation line. No allowance shall be made for costs related to investigation of investment opportunities, travel, entertainment, goodwill, or administrative or managerial activities performed by owners or other related parties that are not directly related to resident care.

Other - "Other" or blank lines have been provided in the each cost center. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report. **Failure to do so will cause the cost report to be deemed incomplete and subject to penalties (General Section, #8).**

For example, other may include miscellaneous expenses incidental to the operation and/or maintenance of the facility and grounds, i.e. trash hauling, snow removal, etc. in the Treatment Facility Operating Cost Center.

Owners/Related Party Compensation - Record the amount earned and reported to IRS for owner/related parties. In order to be allowed, the compensation must be paid within sixty (60) days after close of the cost report period. The amount reported must be in agreement with entries made in Schedule C. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration, as limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions, for managerial and administrative functions, professionally qualified services and other services related to the operation of the PRTF, and was rendered in connection with resident care. All compensation paid to an owner/related party shall appear on the appropriate lines regardless of the label placed on the services rendered (See Kansas Medicaid State Plan).

Owners or related parties, as specified in the Definitions section, who actually perform a necessary function directly contributing to resident care, a reasonable amount shall be allowed for at the lesser of: 1) the cost that would have been incurred to pay a non-owner employee to perform the resident-related services, limited by a schedule of salaries and wages based on the state civil service salary schedule in effect when the cost report is processed; or, 2) the amount of cash and other assets actually withdrawn by the owner or related parties.

Allocation of owner or related party total work time for resident-related functions. When any owner or related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the compensation limit shall be prorated. The time spent on each function within a facility or within all facilities in which the owner or related party has an ownership or management interest shall be prorated separately by function, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time. Owner or related parties performing resident-related functions must be licensed or certified by the state to perform services requiring such credentials.

Salaries paid to non-working owners or other related parties, as defined in the Definitions of the Cost Report Instructions, shall not be considered an allowable cost regardless of the name assigned to the transfer or accrual or the type of provider entity making the payment. Each payment shall be separately identified and reported as owner compensation in the non-reimbursable and non-resident-related expense section of Schedule A in the cost report.

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Rent or Lease Expense – Equipment – Report all recurring rent or lease expense for equipment such as computer leases, copier leases/ telephone equipment leases, etc.

Rent or Lease Expense – Facility - Report all recurring facility rent or lease expense

Resident Transportation - Report resident transportation expense incurred for non-emergency medical, shopping, activities, etc., in which the residents are the primary passengers. Mileage reimbursements for staff use of personal vehicles may be included if the primary passenger is a resident.

This includes fuel, vehicle lease, interest, depreciation (also include on Schedule D), insurance, vehicle repairs and maintenance or other vehicle-related expense. If transportation costs are allocated, trip logs must be kept to document the expense.

For allocation purposes, acceptable methods of allocating cost to Resident Transportation are as follows:

1. Allocated at a set rate per mile. The rate would be determined by dividing total vehicle expense, not restricted to another expense line, by the total miles. The IRS allowed rate per mile is acceptable because it includes factors for depreciation, insurance and repairs.

2. If private vehicles are used to transport residents, the entire amount of the reimbursement paid to the employee for use of the vehicle is allowable as Resident Transportation. The rate of reimbursement must, however, be reasonable.

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Salaries - Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). Salary allocations should adhere to Medicaid cost principles. These lines, plus the owner/related party compensation lines, shall reconcile to your working trial balance.

Report hours paid and the related salaries on the appropriate line for all salaries classifications.

Non-owner/related party administrator compensation shall be reported in the Administration Cost Center. Salaries and benefits of the administrator and co-administrator paid as central office costs shall be included as part of the central office allocated costs.

When any non-owner or non-related party performs a resident-related function for less than a full-time-equivalent work week, defined as 40 hours per week, the work time and compensation shall be prorated on each function within a facility or within all facilities, but shall not exceed 100 percent of that person's total work time. Time spent on other non-related business interests or work activities shall not be included in calculations of total work time.

Report the salaries of the Treatment Facility Operations Cost Center personnel, the salaries of Room, Board, and Support Cost Center personnel, and the salaries of Treatment Cost Center personnel on the appropriate lines in the respective cost center (see salaries classifications list below). **DO NOT REPORT CONSULTANTS ON THESE LINES.**

1. Salaries – Program Director
2. Salaries – Other Administrative Salaries
3. Salaries -- Maintenance Staff
4. Salaries – Housekeeping
5. Salaries – Dietary
6. Salaries -- Laundry
7. Salaries – Licensed Mental Health Professional (LMHP) – an individual who is licensed in the State of Kansas to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP includes individuals licensed to practice independently such as:
    a. Licensed clinical psychologists,
    b. Licensed clinical marriage and family therapists,
    c. Licensed clinical professional counselors,
    d. Licensed specialist clinical social workers, or
    e. Licensed clinical psychotherapists.

    A LMHP also includes individuals licensed to practice under the supervision or direction of:
    a. Licensed masters marriage and family therapists,
    b. Licensed masters professional counselors,
    c. Licensed masters social workers, or
    d. Licensed master level psychologists.

    Supervision or direction must be provided by a person who is eligible to provide Medicaid services and who is licensed at the clinical level or is a physician.

8. Salaries – Mental Health Worker – An individual who is at least twenty-one (21) years of age and meets at least one of the following requirements:
    a. A bachelor's degree; at least 12 credit hours of education in psychology, sociology, social work, counseling, nursing, education, rehabilitation counseling, or theology; and one year of experience in mental health services.
    b. A licensed registered nurse (RN) and one year of experience in mental health

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services.

c. A high school diploma or equivalent and four years of experience in mental health services.
d. A licensed practical nurse (LPN) with one year of experience in mental health services.
e. A licensed mental health tech (LMHT) with one year of experience in mental health services.

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9. Salaries – Direct Care Staff – All direct care staff who are at least twenty-one (21) years of age and at least three (3) years older than the oldest resident; must have a high school diploma or its equivalent.
10. Salaries – Therapy – Other therapy salaries not covered in other classifications.

For owner/related party administrator compensation see the definition "Owner and Related Party Compensation".

Small Equipment - Equipment purchases of $1,000 to $5,000 that were not capitalized must be expensed on this line. Equipment purchases of $1 to $999 may be reported in the cost center of benefit as a supply expense.

Staff Training – Report the costs of fees, tuition, books, etc. for education or training seminars. Training must be pertinent to the job duties and not involve acquiring a degree. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Supplies – Dietary - Report supplies expense directly related to the preparation and service of food to the residents unless further restricted by another expense line. Examples include but are not limited to paper goods, kitchen utensils, etc.

Supplies - Housekeeping - Report all supplies expense related to keeping the building clean and sanitary. Floor care supplies shall be expensed on this line.

Supplies - Laundry and Linen - Report all supplies expense directly related to laundry and linen services for the residents, unless restricted by another line.

Supplies - Nursing - Report expenses of all **routine** supplies directly related to the provision of nursing and/or health related services for residents, unless further restricted by another expense line.

Supplies – Office and Printing - Report all office supplies, postage, duplicating and printing expenses on this line. The printing and duplicating of forms are considered to be an administrative expense and shall **not** be reported in any other cost center.

Supplies - Operating - Report supplies expense incidental to the operation of the applicable cost center. and maintenance of the building, grounds, and equipment in the Treatment Facility Operating Cost Center.

Supplies - Resident Activity - Report the supplies expense involved in providing resident activities.

Taxes - Report all real and personal property taxes in the Treatment Facility Operating Cost Center. Federal income, excess profit taxes, state or local income and excess profits taxes, taxes on property that is not used providing covered services, and interest or penalties paid on any of these taxes are non-reimbursable costs and should be reported in the Non-reimbursable & Non-resident Related Cost Center.

Telephone and Other Communication - Report routine telephone and communications expense in the Administration Cost Center regardless of the department or cost center benefit.

Travel - Report administrative, staff and consultant travel expenses that are related to resident care. Estimates shall not be acceptable. Exceptions:

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1. Long term or recurring vehicle lease expense for business purposes shall be reported on Rent or Lease Expense–Equipment Line or as applicable to treatment on the Resident Transportation Line.
2. Expenses associated with the personal use of a vehicle are not allowable unless reported within otherwise allowable limits of compensation.
3. Resident transportation expense shall be reported in the Treatment cost center outlined in the expense line explanation.

Utilities Except Telephone - Report expenses for gas, water, electricity, heating oil, trash hauling, etc. Cablevision may be considered a utility or resident activity expense.

Non-Reimbursable & Non-Resident Related Items

Provider adjustments must be made in column 3 that offset column 2 expenses in total. Column 4 will show zero expenses.

Costs not related to resident care shall be considered Non-reimbursable costs and reported in this section. In addition, the following expenses or costs shall not be allowed unless noted otherwise below:

Education and Educational Related Expenses -- If a PRTF incurs costs related to school services for youth residing at the facility, these expenses should be included as non-reimbursable & non-resident related expense. These expenses include facility, property equipment and supplies, transportation related to school attendance and staff costs. If certain components of the facility are used as part of a residential treatment plan, e.g. gymnasium, then those costs can be reclassified to the Treatment cost center. Allocation of cost shall be made based on a ratio of resident time usage to the total time the particular facility component is available for usage. If documented as part of a treatment plan, costs associated with time spent by PRTF staff at the school, e.g. providing in-school support for a resident, shall be reclassified to the Treatment cost center. A time study supporting the expense allocation shall be made in accordance with the time study requirements as outlined in the Definitions portion of the cost report instructions.

Fund Raising/Public Relations/Advertising for Resident Utilization -- Include non-allowable advertising expenses. See Advertising and Recruitment explanation under Expense Lines Section.

Insurance - Life – Premiums paid on the lives of owners or related parties.

Membership Fees or Dues – Costs of social, fraternal, civic and other organizations that concern themselves with activities unrelated to their members' professional or business activities.

Non-working Directors or Officers Fees – Fees paid to non-working directors and the salaries of non-working officers.

Other – Expenses such as:

1. the inputted value of services rendered by non-paid workers and volunteers;
2. expenses reimbursed from other state or federal funds;
3. costs of social, fraternal, civic, and other organizations that concern themselves with activities unrelated to their members' professional or business activities;
4. vending machines and related supplies;
5. board of director costs;
6. penalties, fines, and late charges;
7. automobiles and related accessories in excess of $25,000.00 each. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;
8. provider-owned or related party-owned, -leased, or -chartered airplanes and related expenses;
9. bank overdraft charges or other penalties;
10. personal expenses not directly related to the provision of long-term resident care in a PRTF;
11. management fees paid to a related organization that are not clearly derived from the actual cost of

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materials, supplies, or services provided directly to an individual PRTF;
12. business expenses not directly related to the care of residents in a long-term care facility including business investment activities, stockholder and public relations activities, and farm and ranch operations;
13. legal and other costs associated with litigation , unless the litigation is decided in the provider's favor;
14. lobbying expenses and political contributions; or
15. purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses.

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Provision for Income Taxes – Federal income and excess profit taxes, state or local income and excess profit taxes, taxes from which exemptions are available to the provider, taxes on property that is not used in providing covered services; self-employment taxes applicable to individual proprietors, partners, or members of a joint venture, and any interest or penalties paid on these taxes. In addition, interest and penalties paid on federal and state payroll taxes should be included here.

Resident Purchases - Report the expense for items purchased for residents but not listed as routine services or supplies.

SCHEDULE B - EXPENSE RECONCILIATION

General: This schedule shall be used to reconcile the expenses reported on the PRTF Financial and Statistical Report (Form KDADS-PRTF-01) to the provider's financial books and federal tax return.

The cost report automatically calculates the following:

Total Expenses Per Books or Federal Tax Return - Record each cost center total from Schedule A, Column 2.

Total Provider Adjustments - Record each cost center total from Schedule A, Column 3.

Total Resident Related Expenses – Record each cost center total from Schedule A, Column 4.

Total Expenses per Cost Report – Total each Column, lines A through F.

Expenses on Books or Federal Tax Return Not on Cost Report - Itemize each expense reflected in the books or federal tax return and not included in the cost report. These expenses should be recorded in the column 1 under books and/or federal tax return. Use an additional schedule if necessary to list expenses.

Total – Total lines G, H, and I. This total should equal working trial balance (books) or federal tax return.

SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties. Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the Kansas Civil Service wage rates for such activities.

ENTER - Name, Social Security Number and Address
Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job classes should correspond with those included in the Kansas Civil Service classifications for comparable positions.

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense lines

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State of Kansas
Department for Aging and Disability Services

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY COST REPORT

COVER PAGE

SEND TO: Kansas Department for Aging and Disability Services Facilities Reimbursement 503 Kansas Avenue TOPEKA, KANSAS 66603	AGENCY USE ONLY

INSTRUCTIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

	EDS PROVIDER NUMBER (NEED 10 DIGITS)	EMPLOYERS' FEDERAL ID NUMBER
PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.)		**FACILITY NAME**

FACILITY ADDRESS (STREET, CITY, STATE, ZIP)

CONTACT PERSON'S NAME	PHONE NUMBER	CONTACT EMAIL ADDRESS	
		REPORT PERIOD _____ TO _____	TYPE OF ACCREDITATION: Check One _____ CARF _____ COA _____ JACHO Time Period Covered: _____ to _____
	FAX NUMBER	FISCAL YEAR END	

TYPE OF MOST RECENT AUDIT A-133 _____ GAS _____ Other (Specify) _____

CURRENT PRIVATE PAY RATE: _____

CHECK ONLY ONE

Sole Proprietorship ___ Partnership ___ Corp - Profit ___
Corp. - Non Profit ___ City Owned ___ County Owned ___
Other - Government Owned ___ Other (Specify): ___

PRTF BEDS

	TIME PERIOD					
	BEGINNING DATE/DATE OF CHANGE	ENDING DATE	# OF BEDS		# OF CALENDAR DAYS	BED DAYS AT THIS BED COUNT
A.						0
B.						0
C.						0
D.						0
E.						0
F.	TOTAL DAYS DURING REPORTING PERIOD				0	
G.	TOTAL BED DAYS AVAILABLE (TOTAL COLUMN J - LINES A THROUGH E)					0
H.	TOTAL MEDICAID REIMBURSABLE DAYS, EXCLUDING APPROVED ABSENT DAYS					0
I.	TOTAL MEDICAID APPROVED ABSENT DAYS					0
J.	TOTAL RESIDENT "OTHER FUNDED" BED DAYS REIMBURSED					0
K.	TOTAL REIMBURSABLE BED DAYS (TOTAL LINES H THROUGH J)					0
L.	VACANCY PERCENTAGE (1 MINUS K / G)					#DIV/0!

DECLARATION OF PREPARER:

I HAVE COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR

FOR THE COST REPORT PERIOD ENDING _____ , TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH WORKING TRIAL BALANCE (ATTACHED) AS EXPLAINED IN THE RECONCILIATION (SCHEDULE B); THAT I HAVE ALL SUPPORTING DOCUMENTATION OF EXPENSES REPORTED; THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL; AND, THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE NUMBER FAX NUMBER

PREPARER'S EMAIL ADDRESS

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I HEREBY CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH WORKING TRIAL BALANCE (ATTACHED) AS EXPLAINED IN THE RECONCILIATION (SCHEDULE B); THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE AND TITLE OF OWNER, PARTNER, OR OFFICER OF THE CORPORATION, CITY OR COUNTY WHICH IS THE PROVIDER. IF PERSON SIGNING IS NOT AN OWNER OR PARTNER, PLEASE ATTACH DOCUMENTATION OR A RESOLUTION SHOWING THEIR AUTHORITY TO SIGN. (UNLESS ONE HAD BEEN PREVIOUSLY SENT AND ON FILE)

SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
FACILITY ADMINISTRATIVE COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARY - PROGRAM DIRECTOR						
SALARIES - OTHER ADMINISTRATIVE						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY ADMIN COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
STAFF TRAINING						
CONTRACTED LABOR						
MANAGEMENT CONSULTANT FEES						
SUPPLIES - OFFICE & PRINTING						
TELEPHONE & OTHER COMMUNICATION						
TRAVEL						
ADVERTISING AND RECRUITMENT						
LICENSES, ACCREDITATION & DUES						
ACCOUNTING & DATA PROCESSING						
INSURANCE - LIABILITY						
INSURANCE - OTHER						
INTEREST						
LEGAL						
CRIMINAL BACKGROUND CHECK						
TAXES (NOT REAL/PROPERTY)						
MAINTENANCE & REPAIRS						
SUPPLIES - OPERATING						
SMALL EQUIPMENT (SEE INSTRUCTIONS)						
OTHER (SPECIFY)						
OTHER (SPECIFY)						
OTHER (SPECIFY)						
ALLOCATIONS - ATTACH SCHEDULE						
ALLOCATIONS - CENTRAL OFFICE						
TOTAL FACILITY ADMIN COST CENTER	0	$ -	$ -	$ -	$ -	$ -

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
FACILITY PROPERTY COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
INTEREST - EQUIPMENT						
INTEREST - REAL ESTATE						
RENT/LEASE EXPENSE - EQUIPMENT						
RENT/LEASE EXPENSE - FACILITY						
AMORTIZED LEASEHOLD IMPROVEMENT						
DEPRECIATION EXPENSE - EQUIPMENT						
DEPRECIATION EXPENSE - FACILITY						
TOTAL FACILITY PROPERTY COST CENTER		$ -	$ -	$ -	$ -	$ -

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
NON-REIMBURSABLE & NON-RESIDENT RELATED EXPENSE ITEMS (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
BAD DEBTS						
PROVISION FOR INCOME TAXES						
NONWORKING OWNERS/OFFICERS - SCHEDULE C						
MEMBERSHIPS FEES AND DUES						
FUND RAISING/PROMO & NON-REIMBURSABLE ADVERTISING						
LIFE INSURANCE - OWNERS/OFFICERS						
OTHER HEALTH CARE						
VENDING MACHINES						
BOARD OF DIRECTORS EXPENSE						
RESIDENT PURCHASES						
EDUCATION & EDUCATION RELATED EXPENSES						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL NON-REIMBURSABLE		$ -	$ -	$ -	$ -	$ -
TOTAL		#REF!	#REF!	#REF!	#REF!	#REF!

ATTACH A DETAILED DEPRECIATION SCHEDULE AND THE DETAILED WORKING TRIAL BALANCE USED TO PREPARE THIS COST REPORT

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
ROOM, BOARD, AND SUPPORT COST CENTER (Costs for this facility's operation only)	ANNUAL HOURS PAID (1)	FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) RELATED EXPENSES (6)
SALARIES - HOUSEKEEPING						
SALARIES - DIETARY						
SALARIES - LAUNDRY						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
STAFF TRAINING						
CONTRACTED LABOR						
CONSULTANT (SPECIFY)						
FOOD						
SUPPLIES - DIETARY						
LINEN & BEDDING MATERIAL						
SUPPLIES - LAUNDRY & LINEN						
SUPPLIES - HOUSEKEEPING						
SMALL EQUIPMENT						
MAINTENANCE & REPAIRS						
SUPPLIES - NURSING						
SUPPLIES - RESIDENT ACTIVITY						
RESIDENT TRANSPORTATION						
SUPPLIES - TREATMENT						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL ROOM & BOARD COST CENTER	0	$ -	$ -	$ -	$ -	$ -

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
TREATMENT COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARIES - LICENSED MENTAL HEALTH PROFESSIONAL (LMHP)						
SALARIES - MENTAL HEALTH WORKER						
SALARIES - DIRECT CARE STAFF						
SALARIES - THERAPY						
PHYSICIANS, ARNP, PHYSICIAN ASSISTANT						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
CONTRACT PHYSICIAN, ARNP, PHYSICIAN ASSISTANT						
OTHER CONSULTANTS (SPECIFY)						
CONTRACTED LABOR						
LICENSES, ACCREDITATION AND DUES						
STAFF TRAINING						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL SUPPORT & TREATMENT COST CENTER		$ -	$ -	$ -	$ -	$ -
TOTAL	0	#REF!	#REF!	#REF!	#REF!	#REF!

DO NOT CROSS OUT OR RETITLE LINES DO NOT INCLUDE MORE THAN ONE AMOUNT PER LINE.				PROVIDER NAME EDS PROVIDER NUMBER		
SCHEDULE A	**EXPENSE STATEMENT**					
TREATMENT FACILITY OPERATING COST CENTER (Costs for this facility's operation only)	TOTAL ANNUAL HOURS PAID (1)	PER BOOKS OR FEDERAL TAX RETURN (2)	PROVIDER ADJUSTMENTS (3)	RESIDENT RELATED EXPENSES (4)	(AGENCY USE) STATE ADJUSTMENTS (5)	(AGENCY USE) ADJ RESIDENT RELATED EXPENSES (6)
SALARIES - MAINTENANCE STAFF						
EMPLOYEE BENEFITS						
OWNER/RELATED PARTY COMPENSATION - SCHEDULE C						
OWNER/RELATED PARTY EMPLOYEE BENEFITS						
CONTRACTED LABOR						
STAFF TRAINING						
INSURANCE - FACILITY						
TRAVEL						
CONSULTANTS (SPECIFY)						
UTILITIES						
CONTRACTORS FEES						
MAINTENANCE & REPAIRS						
SUPPLIES - OPERATING						
TAXES - REAL AND PERSONAL PROPERTY						
LICENSES, ACCREDITATION & DUES						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
OTHER (PLEASE SPECIFY)						
TOTAL TREATMENT FACILITY OPS COST CENTER	0	$ -	$ -	$ -	$ -	$ -

PROVIDER NAME
EDS PROVIDER NUMBER

SCHEDULE B **EXPENSE RECONCILIATION**

		PER BOOKS OR FEDERAL TAX RETURN (1)	PROVIDER ADJUSTMENTS (2)	RESIDENT RELATED EXPENSES (3)
A	TOTAL EXPENSES - FACILITY ADMINISTRATIVE COST CENTER			
B	TOTAL EXPENSES - TREATMENT FACILITY COST CENTER			
C	TOTAL EXPENSES - FACILITY PROPERTY COST CENTER			
D	TOTAL EXPENSES - ROOM, BOARD, AND SUPPORT COST CENTER			
E	TOTAL EXPENSES - TREATMENT COST CENTER			
F	TOTAL EXPENSES - NON-REIMBURSEABLE			
G	TOTAL EXPENSES PER COST REPORT	$ -	$ -	$ -
EXPENSES ON BOOKS OR FEDERAL TAX RETURN NOT ON COST REPORT				
H	SPECIFY			
I	SPECIFY			
J	**TOTAL (SHOULD EQUAL SUPPORTING BOOKS OR FEDERAL TAX RETURN)**	$ -		

SCHEDULE C **STATEMENT OF OWNERS AND RELATED PARTIES**

LIST ALL OWNERS OF PROVIDERS WITH 5% OWNERSHIP INTEREST & ALL RELATED PARTIES.
SUMMARIZE THE AMOUNT AND NATURE OF TRANSACTIONS WITH ALL OWNERS & RELATED PARTIES.

NAME, SSN, ADDRESS (CITY & STATE)	(1) % OWNERSHIP	(2) % TIME DEVOTED	(3) TOTAL AMT INCURRED	(4) TITLE, FUNCTION OR DESCRIPTION - TRANSACTION	(5) DISTRIBUTION AMOUNT	COST CENTER WHERE INCLUDED
TOTALS (SHOULD BE EQUAL)			$ -		$ -	

CALCULATIONS MUST EQUAL THE OWNER/RELATED PARTY LINES OF THE COST CENTERS

SCHEDULE D	STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE (Costs for this facility's operation only)						PROVIDER NAME / EDS PROVIDER NUMBER		
LENDER'S NAME	LENDER'S ADDRESS	ITEMS FINANCED	ORIGINATION DATE (1a)	DURATION (months) (1b)	INTEREST RATE (2)	ORIGINAL LOAN AMOUNT (3)	UNPAID BALANCE (4)	TOTAL ANNUAL PAYMENTS (5)	INTEREST EXPENSE (6)
TOTALS:							$0	$0	$0

TOTAL OF COLUMN 6 MUST AGREE WITH THE SUM OF INTEREST REPORTED IN THE FACILITY ADMINISTRATIVE COST CENTER AND FACILITY PROPERTY COST CENTER. ATTACH A COPY OF LOAN AGREEMEI AND AMORTIZATION SCHEDULES FOR ALL LOANS OF $5,000 OR MORE IF NOT ALREADY SUBMITTED.

SCHEDULE E REVENUE STATEMENT		PROVIDER NAME EDS PROVIDER NUMBER		
		REV PER BOOKS OR FED TAX RETURN (1)	ADJUSTMENT TO EXPENSE ACCOUNTS (2)	COST CENTER OF RELATED EXPENSE (3)
ROUTINE DAILY SERVICE:				
PRIVATE PAY				
MEDICAID RESIDENTS & PATIENT LIABILITY				
CONTRIBUTIONS AND DONATIONS				
OTHER RESIDENTS (SPECIFY)				
REVENUE FROM MEALS SOLD TO GUESTS & EMPLOYEES				
REVENUE FROM SALES OF SUPPLIES TO RESIDENTS				
PURCHASE DISCOUNTS, RETURNS, REFUNDS & ALLOWANCES				
OTHER SUPPLIES SOLD				
PROGRAM REIMBURSEMENTS & TAX CREDITS				
INVESTMENT/INTEREST INCOME				
VENDING MACHINE REVENUE				
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES REVENUE				
OTHER (SPECIFY)				
OTHER (SPECIFY)				
OTHER (SPECIFY)				
TOTALS		$0	$0	

Be Certain to Off-Set Expenses with Related Revenue Where Appropriate

		PROVIDER NAME EDS PROVIDER NO

SCHEDULE F FIXED ASSET, DEPRECIATION & AMORTIZATION QUESTIONNAIRE

1	DOES THE PROVIDER LEASE OR RENT ANY PART OF THE PHYSICAL FACILITY FROM ANY OTHER ENTITY?.....	☐ YES	☐ NO
2	IF YES, DO ANY OWNERS OF THE PHYSICAL FACILITY HAVE AN INTEREST, DIRECTLY OR INDIRECTLY, IN THE PROVIDER?.....	☐ YES	☐ NO

IF YES, PROVIDE THE OWNERSHIP INFORMATION REQUESTED BELOW. IF NO, GO TO QUESTION 913.

	NAME OF OWNERS OF PHYSICAL FACILITY	% OF OWNERSHIP	DESCRIBE NATURE OF RELATIONSHIP WITH PROVIDER. IF NONE, WRITE "NONE"
3			
4			
5			
6			
7			

IF THE OWNERS ARE OTHER THAN INDIVIDUALS, READ AND FOLLOW THE INSTRUCTIONS FOR LINES 1-7 FOR COMPLEX CAPITAL STRUCTURES.

8	DOES THE LEASE CONTAIN AN OPTION TO PURCHASE THE LEASED PROPERTY?	☐ YES	☐ NO
9	IS THE PHYSICAL FACILITY OWNED BY THE PROVIDER?	☐ YES	☐ NO
10	IF OWNED, WAS THE PURCHASE AN ARMS LENGTH TRANSACTION?..... (ATTACH A STATEMENT OUTLINING DETAILS OF THE PURCHASE)	☐ YES	☐ NO
11	WAS THE STRAIGHT LINE DEPRECIATION METHOD USED?.....	☐ YES	☐ NO
	IF NO, HAVE YOU RECALCULATED THE DEPRECIATION USING THE STRAIGHT LINE METHOD AND MADE THE APPROPRIATE ADJUSTMENTS TO THE DEPRECIATION EXPENSE REPORTED ON THE EXPENSE STATEMENT?	☐ YES	☐ NO