ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Physical Therapy							
1	Physical Therapist Salaries							
2	Physical Therapist Asstnts. Salaries							
3	Physical Therapist Aides Salaries							
4	Other Salaries_							
5	*Subtotal-Salaries*							
6	Employee Benefits Reclassification							
7	*Contracted Services*							
8	Equipment Depreciation							
9	Other Expenses_							
10	Other Expenses_							
11	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col. 4)						
12	*Total*							
	X-Ray							
13	Professional Salaries							
14	Other Salaries_							
15	*Subtotal-Salaries*							
16	Employee Benefits Reclassification							
17	Supplies							
18	Equipment Depreciation							
19	Other Expenses_							
20	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4)						
21	*Total*							
	Laboratory							
22	Professional Salaries							
23	Other Salaries_							
24	*Subtotal-Salaries*							
25	Employee Benefits Reclassification							
26	Supplies							
27	Equipment Depreciation							
28	Other Expenses_							
29	Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4)						
30	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME:

VENDOR NUMBER:

FYE

	(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
	Oxygen/Respiratory Therapy							
31	Respiratory Therapist Salaries							
32	Respiratory Therapist Assistant Sal							
33	Respiratory Therapist Aides Salaries							
34	Other Salaries_							
35	*Subtotal-Salaries*							
36	Employee Benefits Reclassification							
37	Supplies							
38	Equipment Depreciation							
39	Other Expenses_							
40	Other Expenses_							
41	Hospital-Based Indirect Ancillary							
	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col. 4)							
42	*Total*							
	Speech							
43	Professional Salaries							
44	Other Salaries_							
45	*Subtotal-Salaries*							
46	Employee Benefits Reclassification							
47	Equipment Depreciation							
48	Other Expenses_							
49	Other Expenses_							
50	Hospital-Based Indirect Ancillary							
	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4)							
51	*Total*							
	Other							
52	Professional Salaries							
53	Other Salaries_							
54	*Subtotal-Salaries*							
55	Employee Benefits Reclassification							
56	Equipment Depreciation							
57	Other Expenses_							
58	Other Expenses_							
59	Hospital-Based Indirect Ancillary							
	(Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4)							
60	*Total*							

ANNUAL COST REPORT -- SCHEDULE D-5 -- ANCILLARY COSTS

VENDOR NAME:

VENDOR NUMBER:

FYE

(1)	(2) Per Books	(3) Reclass-ifications	(4) Adjust-ments	(5) Adjusted Balance	(6) Direct Costs	(7) Indirect Costs	(8) CNF Indirect Costs
Drugs							
61 Pharmicist Salaries							
62 Other Salaries_							
63 *Subtotal-Salaries*							
64 Employee Benefits Reclassification							
65 Drugs							
66 Equipment Depreciation							
67 Other Expenses_							
68 Other Expenses_							
69 Other Expenses_							
70 Other Expenses_							
71 Hospital-Based Indirect Ancillary	(Sch. D-4, Line 24, Col. 9, X Sch. F, Section B, Line 9, Col. 4)						
72 *Total*							

SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) Increase Amount	(3) Decrease Amount	(4) Cost Center Affected (Schedule & Line # Affected) (e.g. D3-1)
1				
2				
3				
4				
5				
6				
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56				
57				
58				
59				
60				
61	Total			

SCHEDULE D-7
ADJUSTMENTS TO EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

Line	(1) Explanation	(2) * Basis for Adjustment (A) or (B)	(3) Amount	(4) Sch. & Line # Affected (e.g. D3-1)
1	Laundry & Linen			
2	Employee & Guest Meals			
3	Gift, Flower & Coffee Shop			
4	Grants, Gifts & Income Designated by the donor for a specific purpose			
5	Beauty & Barber Shop **			
6	Excess Owners Compensation			
7	Telephone Serv.(Pay Serv. Excluded)			
8	Radio & Television Service			
9	Vending Machine Commission			
10	Sale of Drugs to other than Patients			
11	Sale of Medical & Surgical Supplies to other than Patients			
12	Sale of Medical Record & Abstracts			
13	Sale of Scrap, Waste, Etc.			
14	Rental of Quarters to Emp. & Others			
15	Rental of Facility Space			
16	Trade, Qty, Time & Other Discounts			
17	Rebates & Refunds of Expenses			
18	Interest Not Allowed			
19	Recovery of Insured Loss			
20	Depreciation			
21	Gain or Loss on Disposition of Assets			
22				
23				
24				
25				
26				
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50				
51				
52				
53	*Total*			

* (A) COST (B) REVENUE

** *Beauty & Barber Shop Revenues in excess of Beauty & Barber Shop supply & personnel cost is to be adjusted in an Administrative & General cost center.*

ANNUAL COST REPORT -- SCHEDULE E -- ANCILLARY SETTLEMENT

VENDOR NAME:

VENDOR NUMBER:

FYE

(1)	(2) Direct (From Sch. D-5, Col.6)	(3) Medicaid Direct	(4) Medicaid Payments	(5) Receivable From KMAP (Payable To KMAP)
1 Physical Therapy				
2 X-Ray				
3 Laboratory				
4 Oxygen/Respiratory Therapy				
5 Speech				
6 Other				
7 Drugs				
8 Total				

Medicaid Services use only.

TENTATIVE ANCILLARY	ANCILLARY SETTLEMNT
☐	☐

SCHEDULE F
ALLOCATION STATISTICS

VENDOR NAME: _____ FYB _____ FYE _____

Status _____ VENDOR NUMBER: _____ DAYS _____ MONTHS _____

A. NURSING SALARIES Leap Year ☐ 365 ☐

1. CERTIFIED NURSING FACILITY _____
2. OTHER _____
3. CERT. NURSING FAC. PERCENTAGE _____

ALLOCATION METHOD:

PATIENT DAYS ☐ VALID TIME STUDY ☐
DIRECT COST ☐ DIRECT HOURS ☐
OTHER APPROVED METHOD ☐

B. SQUARE FOOTAGE

	(1) SQ. FT.	(2) PERCENT	(3) HOSPITAL-BASED SQ. FT.	(4) HOSPITAL-BASED PERCENT
1. CERT. NURSING FACILITY				
2. OTHER				
3. PHYSICAL THERAPY *				
4. X-RAY *				
5. LABORATORY *				
6. OXYGEN/RESP. THERAPY *				
7. SPEECH *				
8. OTHER *				
9. DRUGS *				
10. TOTAL				

* For Hospital-Based Certified Nursing Facility Only

C. DIETARY

	(1) MEALS	(2) PERCENT
1. CERT. NURSING FACILITY		
2. ALL OTHER		
3. TOTAL		

ALLOCATION METHOD:
MEAL COUNT: ☐ 3 * INPATIENT DAYS: ☐

D. ANCILLARY CHARGES

	(1) TOTAL	(2) CNF	(3) CNF %	(4) MEDICAID	(5) MEDICAID %
1. PHYSICAL THERAPY					
2. X-RAY					
3. LABORATORY					
4. OXYGEN/RESP. THERAPY					
5. SPEECH					
6. OTHER					
7. DRUGS					
8. TOTAL					

E. OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) OTHER LONG-TERM CARE	(3) ACUTE CARE
1. LICENSED BEDS AT BEGINNING OF PERIOD			
2. LICENSED BEDS AT END OF PERIOD			
3. BED DAYS AVAILABLE			
4. TOTAL PATIENT DAYS			
5. % OCCUPANCY			
6. KMAP PATIENT DAYS			
7. % KMAP OCCUPANCY			

F. ADDITIONAL STATISTICS

1. DIRECT ROUTINE NURSING HOURS - CERTIFIED NURSING FACILITY ONLY	
2. TOTAL DIRECT DIETARY HOURS	
3. TOTAL DIRECT HOUSEKEEPING HOURS	

DISCLOSURE SECTION

VENDOR NAME: ______________________ FYE ________

VENDOR NUMBER: ________

A: STATEMENT OF ORGANIZATIONS CONTRACTED WITH

NAME	TYPE OF BUSINESS	DATE OF CONTRACT		

B: PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

ITEM	AMOUNT			SCHEDULE AND LINE		