EXHIBIT 9

Maryland Department of Health & Mental Hygiene
Nursing Home Uniform Cost Report (UCR) Under Title XIX

GENERAL INSTRUCTIONS

The Principles of Reimbursement and the regulations pertaining thereto applicable to Medicare (Title XVIII) and Medicaid (Title XIX) must be followed in the completion of the cost report. These principles and regulations are contained in 42 CFR, Part 405 - "Federal Health Insurance for the Aged and Disabled" (formerly "Regulations No. 5 - Federal Health Insurance for the Aged - Subpart D" - HIRM-1), "Provider Reimbursement Manual" - CMS Pub. 15 and COMAR 10.09.10.

Amounts included for all elements of cost must be determined in accordance with the aforementioned Principles of Reimbursement.

A number of the schedules in the cost report provide an account number for each line. These account numbers are contained in the Uniform Account Descriptions (U.A.D.) which provides definitions for transactions to be included in the account. Preparation of the schedules in the cost report should follow the definitions in the U.A.D.; however, providers are not required to keep their books on the basis of the U.A.D.

The account numbers in the U.A.D. were developed in such a manner as to be similar to the American Health Care Association Recommended Chart of Accounts. The U.A.D. contains a comparison of American Health Care Association accounts and the accounts used in the cost report.

All cost reports must be filed using the accrual basis of accounting covering the provider's fiscal year. All amounts must be reflected as whole dollars, and cents must not be used.

Cost reports must be prepared by both the prior and current owners of a nursing home if the home was sold during the current period. Each owner should complete the form for the period during which the home was owned.

ELECTRONIC SUBMISSION

Effective for cost report periods ending June 30, 2007 and later, cost reports must be filed electronically. Cost report periods ending prior to June 30, 2007 may be filed electronically at the discretion of the provider.

To electronically submit a cost report, send a Submission File to the address listed below. The Submission File format is found in the first tab of the UCR template. The UCR template is available for use in completing and submitting the cost report, but use of the UCR template is not required. Providers may use their own templates or software to complete the cost report. However, the Submission File format from the UCR template is the only allowable format for electronically submitting a cost report. The Submission File may be e-mailed or saved on a CD or diskette and submitted with the paper support documents.

The following paper support documents must also be submitted to the address listed below:

- One copy of Schedule A with an original signature in the Cost Report Certification section.
- Attachments to support amounts reported on the cost report, as needed. Each attachment should be clearly labeled with the schedule and line(s) it is supporting.
- A copy of the provider's financial statements or trial balance.
- Loan agreements and amortization schedules for any new loans initiated during the cost report period.
- Key Personnel Compensation Questionnaire(s) (if required).
- Related Organization Questionnaire (if required).
- Invoices and proof of payment to support submitted Real Estate Tax Expense.
- Bed licenses and/or bed change request letters and approval letters for the period covering the cost report.

All electronic cost report files and paper support documents should be mailed or delivered to:

Myers and Stauffer LC
400 Redland Court, Suite 300
Owings Mills, MD 21117
(410) 356-9256
(410) 356-0188 fax
mducr@mslc.com

Both the electronic cost report submission and the paper support documents must be received by the filing deadline. If the electronic cost report submission and paper support documents are not both received by the filing deadline, the provider will be subject to the sanctions described in COMAR 10.09.10.13.

Final Review Certification Form

Effective for cost report periods ending June 30, 2008 and later, the Final Review Certification Form has been discontinued. The cost report data that is filed electronically is compared to the signed Schedule A that is submitted. The provider will be contacted if there are discrepancies between the electronic data and the signed Schedule A.

Documents for Download

The following documents are available for download at www.mslc.com/maryland. From this website, select the Services link and then the Resources link. From the Resources page, select the Data Collection Tools folder to list all of the files available for download. To download a file, right-click on the file name. When the pop-up menu appears, select the Save Target As menu option. Use the Save As dialog box to save the file to your PC.

- UCR Instructions
- UCR Template (Blank and Numbered)

Exhibit 9

- UCR Template Instructions
- UCR Template Modifications
- Key Personnel Compensation Questionnaire
- Related Organization Questionnaire

SPECIFIC INSTRUCTIONS

Note

The following instructions are written as if the UCR is completed manually. Instructions are given on amounts that are transferred between schedules and how totals are calculated. The UCR template contains all of the amounts that flow to other schedules and total calculations. Please refer to the UCR template for a detailed description of how the cost report values are calculated.

Index (Page 2)

Indicate in the last column whether each listed schedule has been included. Providers should include either Schedule P or Q, and either Schedule R or S, as explained in the instructions to these schedules. Schedules M, N, V, and W should be included only if the activities reported in these schedules are conducted. All other schedules are mandatory.

Occupancy and Rate Data (Page 3)

Part I - Inpatient Days - Total inpatient days by month are to be reported by type of service rendered (Comprehensive Care, Domiciliary Care, etc.). Columns 1, 2, 3, and 4 must include only Comprehensive Care. A patient day is the care of one patient during the period between the census-taking hour of two successive days. Count day of admissions, but not day of discharge or death (unless death occurs at a hospital). Leave days and hospital days are to be counted. When a patient is admitted and discharged on the same day, this must be counted as one inpatient day.

Medicaid Hospice Days Column – Report all days paid by the Medicaid hospice program in this column. Do not report these days in any other column.

Medicare Part C Days – Report Medicare Part C days in the Other Govt. column. Do not report these days in any other column. The Other Govt. column should also include any other days that the facility has historically reported in the Other Govt. column.

Part II - Bed Capacity - Total beds, as licensed by the Licensure Unit of the Department of Health & Mental Hygiene, are to be listed in the spaces provided. Temporary changes in bed complement, because of voluntary restrictions, do not affect bed capacity. Explain dates and changes in an attachment to Line 17, if more than one change to the number of licensed beds occurs during one cost report period.

Bed days available are determined by multiplying the number of beds available in the reporting period by the number of days in the period. Take into account increases or decreases in the

number of beds available and the number of days elapsed since the increases or decreases. As an example, for a provider on a June 30 fiscal year, if the number of licensed beds increased from 50 to 100 as of October 1 of the reporting period, the calculation would be as follows:

50 beds for 92 days - 4,600 bed days available
100 beds for 273 days - 27,300 bed days available
31,900 bed days available during the period

Part III - Percent Occupancy - The percent occupancy should be computed for each category in which bed capacity information has been provided.

Part IV - Daily Minimum Semi-Private Rates as of Last Day of Reporting Period - The minimum semi-private rates must include only those charges for services comparable to those included in the Medicaid patient rate. Refer to COMAR 10.09.10 for further information on charges includable in the Medicaid patient rate.

Page 4

Page 4 includes the certification required to be signed by owner, officer or administrator as indicated on the schedule. UNSIGNED REPORTS OR PHOTOCOPIED SIGNATURES WILL NOT BE ACCEPTED. AN ORIGINAL SIGNATURE IS REQUIRED ON THE COST REPORT CERTIFICATION PAGE MAILED OR DELIVERED TO THE ADDRESS LISTED ABOVE.

Schedule A and Comments Related to Schedules B Through I

Schedules B through J provide the means to accumulate the information required for Schedule A. Specific cross-references to the pertinent schedule are included in the Schedule A format. All financial information listed must be determined under generally accepted accounting principles.

The basic format of the schedules follows the Uniform Account Descriptions. Note that the account numbers have been grouped to accumulate information by the cost centers on Schedule A. Certain departmental accounts are needed only if the provider carries on these activities.

Refer to Schedule J where adjustments to expenses are summarized by type of adjustment. Such adjustments are to be entered in the adjustment column of Schedules D through H and L for the appropriate expense account, to arrive at the "As Adjusted" amounts. Negative numbers should be designated with brackets. Also, refer to Schedule N where an allocation of operating expenses is made to non-patient care areas, where applicable; to Schedule M where Central Office Overhead is allocated to departments and/or management fees to related parties are adjusted to cost; and to Schedule L where employee benefits are allocated to departments. The results of these allocations, if applicable, are entered in the adjustment columns of Schedules D, E, F, G, and H.

After all adjustments have been reflected, the "As Adjusted" totals for all Schedule D through H line items should be determined and the "As Adjusted" totals, by cost center, entered in Column 3 of Schedule A.

No adjustments are made to Schedule I; only the book figures on Schedule I are carried forward to Schedule A, Column 2. Schedule A, Line 17, must agree with net income or loss reflected on the provider financial statements.

Schedule B

Use Line 4 for V.A. and 'non-Maryland" Medical Assistance patients. Include on Lines 28-30 revenue from services not listed on the form, such as personal nursing, day care and transportation. Provide an attachment with details for any revenues listed on Line 30.

Schedule C

Self-explanatory.

Schedule D

Note that non-reimbursable services are not extended to Column 3; thus, the total carried forward from Schedule D, Column 3, Line 15 to Schedule A, Column 3 includes only Nursing Care Service from Line 9. Proper completion of Line 7 is critical to equitable nursing rate calculations. DO NOT "write in" nursing benefits on any other line. Nursing Vacation, Holiday and Sick Pay should be reported on Line 7. Also, refer to * on Schedule D. Food supplements used in tube feeding are to be entered on Line 5. See the instructions below for reporting Ventilator Care costs on Schedule D.

Report supplies associated with Negative Pressure Wound Therapy (such as dressings and containers) on Line 2 with other nursing supplies.

Ventilator Care

The payment rates for Ventilator Care include consideration for Nursing costs as well as selected costs otherwise includable in cost centers other than the Nursing Service cost center. Accordingly, those costs must be eliminated from their respective cost centers to avoid having those costs being reimbursed more than once. Further, in order to accurately establish and/or assess future Ventilator Care payment rates, it is necessary to accumulate the related allowable costs incurred. Schedule D-1 has been eliminated for cost report periods ending 06/30/2007 and later.

Costs related to the provision of Ventilator Care are to initially be included on the appropriate line of Schedules D thru H. Costs over and above the costs of basic care incurred exclusively for providing Ventilator Care are then eliminated from their respective cost center by a negative entry on Schedule J to the schedule and line on which the costs are included. A corresponding positive entry is to be made on Schedule J to Schedule D, Line 8a.

If any Depreciation on Major Equipment is allocated to Ventilator Care, attach a depreciation schedule to support the amount allocated. If any Interest on Major Equipment is allocated to Ventilator Care, attach an amortization schedule to support the amount allocated.

When considering employee benefits, be certain that the Schedule L allocation has been determined first, if appropriate.

If costs are allocated for Ventilator Care, include an attachment to Schedule D stating the total number of patient days that Ventilator Care was provided in beds licensed for Ventilator Care and the total number of patient days for which the Maryland Medical Assistance Program was billed for Ventilator Care. Note that Page 3 of the UCR is unaffected by the number of Ventilator Care days.

Schedule E

Physical Therapy, Occupational Therapy, Speech Therapy, Laboratory, Radiology and Prescription Drug costs are not extended to Column 3. These amounts must be removed through adjustments on Schedule J.

A major change, effective October 1, 1999, is the deletion of all therapy costs from the Other Patient Care cost center. A Schedule J adjustment to Lines 4 - 6 should be used to eliminate all Physical Therapy costs incurred on or after October 1, 1999. A Schedule J adjustment to Lines 24 – 26 should be used to eliminate all Occupational Therapy costs incurred on or after October 1, 1999. Employee Benefits applicable to any Physical Therapy and Occupational Therapy salaries incurred on or after October 1, 1999, should be eliminated from Line 39.

Schedule F

Self-explanatory.

Schedule G

Report arms-length management fees to non-related parties at Line 4.

Report management fees to related parties at Line 5, Column 1, which should be eliminated (through Schedule J, Line 34) in Column 2. Actual management costs or central office overhead should be substituted in lieu of these fees through Schedule M. Refer to instructions for Schedule M.

Adjust Line 16 as explained in the instructions to Schedule L below. An adjustment to remove these benefits must be entered on Schedule J.

Lines 19 - 29 should be used to report any other expenses contained in the Administration section of the Uniform Account Descriptions which the provider incurs.

Quality Assurance expenses must be reported on Lines 41-43. Quality Assurance Salaries and Wages should include the wages of all personnel performing Quality Assurance duties.

Schedule H

Expense listed on Lines 1 - 9 will be included in reimbursable costs at the actual, allowable amount. Property taxes and insurance paid by the landlord in non-investor operated facilities may be included via a Schedule J adjustment if properly documented and verifiable. Expenses on Lines 10 - 16 will be reported on Schedule H using the appropriate reimbursement rules, but these expenses will be replaced by the Net Capital Value Rental allowance in calculating reimbursement rates. Report the listed expenses for all capital assets, except for automobiles (transportation equipment, which is reported on Schedule G), and certain minor equipment items not included in the definitions of capital assets. Report expenses for minor equipment on Schedule F, Line 25. DO NOT ATTEMPT TO CALCULATE NET CAPITAL VALUE RENTAL AND INCLUDE IT ON THIS SCHEDULE.

Report Quality Assessment payments on Line 4 Other Property Taxes.

Report the following items on Lines 10 – 14. These lines should also include any other costs that the facility has historically reported on these lines.:

- The cost of the pump for Negative Pressure Wound Therapy. (Report the supplies costs on Schedule D, Line 2.)
- The cost of Bariatric Bed purchase, rental or repair.
- The cost of Power Wheelchair purchase, rental or repair.

Schedule I

Self-explanatory. If additional lines are needed for non-reimbursable expenses, include the amounts in the Line 32 total and provide details in an attachment.

Schedule J

(Refer to CMS Pub. 15 and COMAR 10.09.10 for Principles of Reimbursable Costs.)

All adjustments to expenses per books, other than those on Schedules L, M, and N, are summarized on this schedule. Line descriptions indicate the more common activities which affect costs or result in costs incurred not applicable to patient care, thus requiring adjustment. Schedule J should be used to adjust any costs of the types indicated which are reported in Schedules D through H, but not if reported on Schedule I. The amounts entered on Schedule J should be noted "A" in the Basis Column where the facility can determine costs. Where costs are not determinable, the notation "B" should be entered to indicate that the amount received for the service is the basis for the adjustment.

Adjustments which may be necessary include, but are not limited to, revenues which are considered recoveries of cost (sale of meals, purchase discounts or rebates of expenses, etc.) or direct expense adjustments not allowed by specific regulations (bad debts and excessive owner's

compensation, etc.). The Principles of Reimbursement under Medicare will apply except for cost of items specifically excluded from the Maryland Medicaid Plan, e.g. prescription drugs.

The schedule and line number must be provided for each line item, to indicate where the adjustment will be recorded in Schedules D through H. Certain adjustments resulting from cost allocations (or where an amount received is used as a basis for the adjustment, etc.) will be difficult to relate to a specific account number. A separate line item has been established in each cost center in Schedules D through H to reflect such adjustments, described as "Adjustments Not Related to Specific Accounts." Each adjustment should be entered in the adjustment columns of Schedules D through H on the line where the related cost is reported. Where the amount received is used as the basis for adjustment, the amount of the adjustment will generally agree with the revenues reported on Schedule I. Any clarifying comments that will help substantiate the position taken can be included in Column 4. If the space is not adequate, a statement should be attached.

Any adjustments not computed through an existing supporting schedule in the cost report or determined by using the amount received per Schedule I, may require additional clarification through a supporting computation and explanation attached as an exhibit to this schedule.

Income generated by the sale of meals includes recovery of both raw food cost and dietary salaries and supplies. Any income generated by the sale of meals should, therefore, be carried forward to Schedule E, Line 33 (Raw Food) and Schedule F, Lines 1 - 6 (Other Dietary Costs). The income should be prorated in the ratio of the costs reported on Line 33 of Schedule E and Lines 1 - 6 on Schedule F. Schedule J, Line 3 may be used for one of these adjustments. The remaining adjustments need to be entered on Schedule J, Lines 35 to 130.

Line 6 should be used to eliminate the cost of prescription drugs on Schedule E, Line 11.

Schedule J should be used to eliminate physical therapy and occupational therapy costs incurred <u>on or after</u> October 1, 1999.

Schedule J must be used to remove the employee benefits reported on Schedule G, Line 16.

Schedule J should not be used for year-end conversion of cash basis books to the accrual basis. The Balance Per Books columns of Schedules A through I should reflect the accrual basis of accounting as required by COMAR 10.09.10. When cash basis books are maintained, schedules supporting year-end conversion to the accrual basis should also be part of a provider's basic accounting records. Use Lines 35 - 130 of Schedule J for any adjustment not printed on the form.

Schedule K

Schedule K is provided to show on Lines 1 through 5 the compensation included in cost for the period, of sole proprietors, partners, and corporate officers, as owner(s) of facilities <u>and</u> to disclose total provider ownership. Lines 6 through 8 are provided to show compensation paid to employed person(s) to perform duties as administrators and/or assistant administrators. Lines 9

through 14 should be used for compensation to owners' relatives. Compensation is defined as the total benefit received or receivable for the services rendered to the institution. It includes salary amounts paid for managerial, administrative, professional and other services; amounts paid by the institution for the personal benefit of the individual shown (including, but not limited to, employee benefits and life insurance); the cost of the assets and services which the individual shown receives from the institution; and deferred compensation. The amounts shown should be the totals before any adjustments made in Column 2 of Schedules D - H.

Schedule L

Employee benefits are defined in the Uniform Account Descriptions. These costs should be reported in Schedule G, Line 16. The purpose of Schedule L is to assign these employee benefits to the cost centers where the applicable employee's compensation is reported. Lines 1 - 11 of Schedule L should be used to identify the content of the employee benefits amount on Schedule G, Line 16. Lines 12 - 41 should then be used to allocate the total employee benefits cost to departments on the basis of gross salaries in each department.

Enter in Column 7, Lines 12 - 40 the gross salaries from the schedule shown in Column 6 (e.g. Nursing Care Service gross salaries from Schedule D, where it appears as Line 1). Do not include any amounts other than employee salaries in Column 7. Do not include contracted services in Column 7. It may, in some cases, be necessary to adjust the salaries used in this calculation in order to make the allocation more equitable (e.g. salaries in excess of FICA limits). Enter these adjustments in Column 7a. Enter the sum of Columns 7 and 7a in Column 7b.

After entering all gross salaries shown in Schedules D, E, F, G, and I, total Columns 7, 7a, and 7b. Complete Columns 8a and 8b by allocating the amount on Line 11, Column 3 to each department by each department's percentage of total gross salaries using the amount in Column 7b. This sum of Columns 8a and 8b should agree with Column 3, Line 11.

Providers who can charge employee benefits directly to departments are required to do so if a more accurate reporting of benefits in the department where the applicable employee's compensation is reported results. For example, actual FICA expenses for each employee may be charged directly to departments with each employee's salary. When this alternative is followed, only the employee benefits which are not so handled should be reflected on Schedule L. Attach a supporting schedule, and use the lines provided on Schedules D - G for the benefits charged directly to departments.

If direct costing such as described is followed, any subsequent method change to allocation by gross salaries will require the permission of the Department.

Upon completion of Schedule L, an adjustment must be made on Schedule J to eliminate employee benefits on Line 16, Schedule G and corresponding increases should be made to expenses by department on Schedules D, E, F, and G. Enter the Column 8 amount for each group of departments on the schedule and line shown in Columns 5 and 6. Example: Nursing Care Service - enter Column 8, Line 12 to Schedule D, Line 7.

Schedule M

This schedule is required for providers who claim either: (a) management fees to a related party, or (b) costs which are allocated to them by a home office or division of a related company. These costs are first reported at Schedule G, Line 5, and then adjusted to reflect the allowable portion allocable to the provider via Schedule M. The provisions of Medicare Provider Reimbursement Manual Part I, Section 2150-2153 should be followed. Column 1 should include the total allowable expense incurred by the central office for each of the expenses listed in Lines 1 through 42, which are included in the costs claimed for reimbursement herein. Any other claimed expenses from a central office not provided for by Lines 1 through 31 should be added in Column 1 and explained in Lines 32 - 41.

In Column 2, show the percentage of each line allocated to this facility. For example, if the central office provides accounting for ten facilities at a total cost of $100,000, "$100,000" would be shown in Column 1 and "10%" might be shown in Column 2 (if one-tenth were allocated to this facility). Percentages should be rounded to four decimal places (0.1523 or 15.23%).

In Column 3, show the method used to allocate costs on each line between all the facilities and operations receiving services. For example, if accounting is allocated by total patient days of each facility, enter "patient days." Supporting schedules should be attached, where necessary, to explain the allocation. Medicare CMS Pub. 15, Section 2150.3 should be followed in the allocation bases used.

In Column 4, show the related party or central office cost allocable to the provider and adjust the schedule and line shown in Column 5 by the Column 4 amount. Also, refer to the instructions for Schedule G, Line 5 above.

Adjust related-party management fees in Schedule G, Line 5 to the related party's cost as reflected in Schedule M, Column 4 by removing such fees via Schedule J, Line 34, and increasing the schedules and lines shown in Schedule M, Column 5. Reclassify central office costs allocated to the provider in Schedule G, Line 5 by crediting G-5 in Column 2 via Schedule J, and increasing the schedules and lines shown in Schedule M, Column 5.

See Schedule O instructions for further information on related parties.

Schedule N

Note that this schedule does not have to be prepared if there are no non-patient care (i.e. non-comprehensive) areas.

The purpose of this Schedule N is to isolate expenses included in patient care cost centers related to non-patient care activities. Such expenses are not allowable costs for Medicaid reimbursement purposes and should be removed from the patient care cost centers. Examples of non-patient care areas are included in Schedule N, Page 19, Columns 1 - 4.

Detailed instructions for the allocation of expenses to non-patient areas are as follows:

Page 19, Columns 3, 3a, and 3b – Column 3 must reflect the total "As Adjusted" expenses reported on Schedules D through H. Column 3a is used to report any adjustments to these amounts prior to Schedule N allocation. Column 3b is the sum of Columns 3 and 3a reflecting expenses before this allocation. This amount will be used to calculate the expense allocation to non-patient care activities in Column 5.

Page 20, Columns 1 - 6 - Certain common non-patient care areas have been listed. This list is not all-inclusive and space has been provided (Columns 5 and 6) to list any such area peculiar to a particular provider. Include here, rental of apartments, parking, flower shops, etc. Schedule N, Page 20, requires that statistics of each non-patient care area be listed in Columns 1 - 6 and for the patient care areas (in total) in Column 8, so as to compute each area's percentage relationship to the total. The recommended statistical allocation bases are shown on Schedule N, Page 20. All statistics used in these allocations must be supportable by records. As a general example:

	Square Feet/	% of Total
Domiciliary Care	200	10%
Coffee Shop	100	5%
Gift Shop	100	5%
	400	20%
Comprehensive Care	1,600	80%
	2,000	100%

Based on the above, 20% of the adjusted costs of the cost centers allocated on the basis of square feet would be allocated to the non-patient care areas. The total allocated to each cost center (Page 19, Column 5) would be transferred to Schedules D, E, F, G, or H (at the lines shown in Column 7) as an adjustment to allowable costs.

Page 20, Line 40 - Administration costs are allocated on the basis of Accumulated Cost. Use Page 19, Column 3b, Line 39 for total basis and Page 19, Column 5, Line 39 for Accumulated Costs.

Schedule O

"Not Applicable" or "N/A" are not acceptable responses. YES OR NO MUST BE INDICATED.

All related non-party transactions are to be summarized on this schedule. (Refer to Chapter 10 of PRM for an explanation of what constitutes a related party and how this can affect reimbursable costs.) In general, "related to the provider" means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, supplies, etc. Further, costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common

ownership or control are includable in the allowable costs of the provider at the cost to the related party. Such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

However, payments to related parties operating on an arms-length basis would be included in allowable costs on the basis of charges. Refer to Section 1010 of PRM for further details on this exception to related-party principle.

Each category of related-party data on Lines 3 - 12 should be described. The following is additional information applicable to some of the costs which should be listed:

- ◊ Lease expenses from a related party are not allowable expenses. However, the costs of ownership of the related party are allowable.
- ◊ Contracted services, management agreements and home office allocations should be shown here and on Schedules G and M. Any portion of these costs in excess of the price of comparable services available elsewhere should be entered on Schedule J.
- ◊ Supplies and other purchases from a related party are allowable only to the extent of the cost to the related party. They should also be shown in the schedule reporting the department involved (D through I).

Schedules P and Q

Facilities should complete Schedule P or Q, depending upon facility ownership. The analysis of capital information will be obtained from a review of the general ledger accounts summarized in the column headings.

Schedules R and S

Facilities should complete Schedule R or S, depending facility ownership.

The balance sheet formats are consistent with the Uniform Account Descriptions detailed in the Uniform Accounting and Cost Report Manual. The account numbers from the Uniform Account Descriptions have been provided for each line item required for the balance sheets. The provider is required to use the accrual basis of accounting.

Recipient funds (Patient Trust Funds) are to be maintained separately from the provider's funds. Refer to COMAR 10.09.10. It is required that recipient funds and the related liability be separately stated in Schedule X.

Schedules T and U

The analysis of fixed assets and related depreciation is presented in two segments: Schedule T is a summary of total assets and Schedule U is a summary of depreciation, which also reports depreciation on those assets that are not related to patient care.

A separate line is available for capitalized leases (Schedule U, Line 11). Detailed information on these leases is required on Schedule W.

Schedule T - List the total cost by property category. The applicable account number from the Uniform Account Descriptions has been provided. The total of Column 5 must agree with the amount reported in Schedule R or S.

Schedule U - List the accumulated depreciation by property category. The total of Column 5 must agree with the amount reported on Schedule R or S. The information required for those assets not related to patient care is similar to that described above. However, depreciation for such assets is not allowable (e.g. a boat or mobile home not required for patient care). The total depreciation shown in this section should be entered on the appropriate line of Schedule J. Note that if these assets are part of the allocation to non-patient care areas on Schedule N, or if the depreciation has already been included on Schedule I in the non-allowable cost sections, no further adjustment is required on Schedule J.

Schedule V

Include Debt and interest of the landlord if this is a related party. Loan agreements and amortization schedules for any new loans must be submitted with the cost report in the first loan year.

Schedule W

All lease arrangements, except for autos, must be summarized on this schedule; leases that have not been capitalized should be listed in Part I and those leases that have been capitalized should be listed in Part II.

The column headings are self-explanatory as to the information required. Any lease indicated as being with a related party (in Column 4) should be listed in the appropriate section of Schedule O This requirement applies whether the lease has or has not been capitalized. The total rent expense, or amortization expense in the case of capitalized leases, must also cross reference forward to Schedules H and U as indicated.

Schedule X

The line items to be reported on this schedule cover the funds held by the provider either on hand or deposited in a bank account in trust for patients. The amount held must be reported in full.

Schedule Y - Open

Schedule Z - Questionnaire/Checklist

This schedule is self-explanatory and is mandatory for all providers.