

**Ohio Department of Job and Family Services
CAPITAL COMPENSATION COST REPORT**

INSTRUCTIONS: The filing of the Capital Compensation Cost Report is pursuant to Section 606.18.06 of Am. Sub. H.B. 530. PLEASE ROUND TO THE NEAREST DOLLAR FOR ALL ENTRIES MADE ON THIS COST REPORT. When completed, file with the Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215

The completion of this form is to determine eligibility and payment for the capital compensation program and should reflect costs associated with all assets currently in service except those assets placed into service after December 31, 2003 that are not related to the qualifying capital project.

In addition to submitting the completed "Capital Compensation Cost Report" a provider must also submit the IRS Form W-9 "Request for Taxpayer Identification Number and Certification " and a depreciation/amortization schedule for the qualifying eligible capital activity.

Provider Name (DBA)	National Provider Identifier	Medicaid Provider Number	Medicare Provider Number
Complete Facility Address:		Federal Tax ID Number	Period Covered by Cost Report
Contact Person:			
Address (1)		ODH ID Number	From:
Address (2)			
City	State of Ohio	County	Through:
Zip Code			
		Medicaid Certified Beds Only	Total Facility Licensed Beds
		(1)	(2)
ALL PATIENTS			
1. Licensed beds at beginning of period			
** 2. Licensed beds at end of period			
3. Total bed days available			
4. Total inpatient days			
5. Percentage of occupancy (line 4 divided by line 3 X 100)			
Nursing Facilities:			
ICFs-MR:			

**IF LINE 2 IS DIFFERENT FROM COL. 1, LINE 1, NOTE DATE OF CHANGE _____ AND NUMBER OF BEDS INVOLVED IN CHANGE _____

**Ohio Department of Job and Family Services
CAPITAL COMPENSATION COST REPORT**

Program Eligibility Dates:

Please check the appropriate box to specify the division of Section 606.18.06 under which the facility qualifies for the Capital Compensation Program and provide the requested information:

_____ **Section 606.18.06 (B)(1)**

Date the NF obtained certification as a NF from the Director of Health: _____
 Date the NF began participating in the Medicaid program: _____
 Date the application for certificate of need was filed with the Director of Health: _____

_____ **Section 606.18.06 (B)(2)**

Date the ICF-MR obtained certification as an ICF-MR: _____
 Date the ICF-MR began participating in the Medicaid program: _____
 Date the ICF-MR had materials or equipment delivered: _____
 Date the ICF-MR began preparation for the physical site, including if applicable, excavation: _____
 Date the ICF-MR began actual work on the facility: _____

_____ **Section 606.18.06 (B)(3)**

Date the certificate of need was filed with the Director of Health: _____
 Date the NF completed the qualifying eligible capital activity: _____
 Date the NF had materials or equipment delivered: _____
 Date the NF began preparation for the physical site, including if applicable, excavation: _____
 Date the NF began actual work on the facility: _____
 Was the project undertaken to comply with rules adopted by the Public Health Council regarding resident room size or occupancy? _____ Please provide Rule Citation _____

_____ **Section 606.18.06 (B)(4)**

Date the ICF-MR completed the qualifying eligible capital activity: _____
 Date the ICF-MR had materials or equipment delivered: _____
 Date the ICF-MR began preparation for the physical site, including if applicable, excavation: _____
 Date the ICF-MR began actual work on the facility: _____

_____ **Section 606.18.06 (B)(5)**

Date the NF completed the qualifying eligible capital activity: _____
 Date the NF filed with the Director of Health for a determination of a reviewable activity: _____
 Date the NF had materials or equipment delivered: _____
 Date the NF began preparation for the physical site, including if applicable, excavation: _____
 Date the NF began actual work on the facility: _____
 Was the project undertaken to comply with rules adopted by the Public Health Council regarding resident room size or occupancy? _____ Please provide Rule Citation _____

_____ **Section 606.18.06 (B)(6) - Nursing Facilities**

Date the NF completed the renovation for the qualifying capital activity: _____
 Date the NF received approval for renovation from the Director of Job and Family Services: _____
 Date the NF had materials or equipment delivered: _____
 Date the NF began preparation for the physical site, including if applicable, excavation: _____
 Date the NF began actual work on the facility: _____
 Was the project undertaken to comply with rules adopted by the Public Health Council regarding resident room size or occupancy? _____ Please provide Rule Citation _____

_____ **Section 606.18.06 (B)(6) - ICF-MR**

Date the ICF-MR completed the qualifying eligible capital activity: _____
 Date the ICF-MR received approval for renovation from the Director of Job and Family Services: _____
 Date the ICF-MR had materials or equipment delivered: _____
 Date the ICF-MR began preparation for the physical site, including if applicable, excavation: _____
 Date the ICF-MR began actual work on the facility: _____
 Was the project undertaken to comply with rules adopted by the Public Health Council regarding resident room size or occupancy? _____ Please provide Rule Citation _____

CERTIFICATION BY OFFICER OF PROVIDER

Provider Name	Medicaid Provider Number	Reporting Period From:	Through:
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In accordance with the Medicaid Agency Fraud Detection and Investigation Program rule 42 CFR 455.18 (REV. 10/05). all cost reports submitted to ODJFS will be certified as follows:

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER FEDERAL AND STATE LAWS AND PUNISHED BY FINE AND/OR IMPRISONMENT.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules and attachments prepared for (name of provider) _____, Medicaid Provider Number _____ for the cost report period beginning _____ and ending _____ and that to the best of my knowledge and belief, it is a true, accurate, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

Signature of Owner, Officer, or Authorized Representative of Provider		Date of Signature
Print or Type Name of Owner, Officer, or Authorized Representative of Provider		
(Last)	(First)	(M.I.)
Title	Telephone Number Area code ()	Fax Number Area Code ()

Report Prepared by (Company)		
Report Prepared by (Individual)		Title
(Last)	(First)	(M.I.)
Address		
City, State, Zip Code		
Telephone Number of Person Preparing Cost Report Area Code ()		Fax Number Area Code ()
Location of Records or Probable Audit Site		Telephone Number for Audit Contact Person Area Code ()
Address		County
City	State	Zip Code

NOTARIZED

Subscribed and duly sworn before me according to law, by the above named officer or administrator this _____ day of _____ 20____ at _____, county of _____, and state of _____.

Signature of Notary

QUALIFYING CAPITAL COSTS INFORMATION-NURSING FACILITIES (ONLY)

Schedule A

Provider Name	Medicaid Provider Number	Reporting Period From: Through:
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ASSETS ACQUIRED

CAPITAL COSTS 1	Chart of Account 2	Total 3	Adjustment Increase (Decrease) 4	Adjusted Total Col 3 + Col 4 5	Alloc. *** 6	Allocated Adjusted Total Col 5 x Col 6 7
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant & Equip.	8070					
9. Amortization of Financing Costs	8080					
Nonextensive Renovations -	8085, 8086,					
10. Depreciation/Amortization and Interest	8087					
11. Home office costs - capital **	8090					
12. TOTAL Capital Costs Group A						

** Home Office Costs are to be entered on line 11 only. They are not to be distributed to any other line.

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT - NURSING FACILITIES (ONLY)

ASSETS ACQUIRED

ACCOUNT	Date Acquired 1	Cost at Beginning of Period 2	Additions or Reductions 3	Cost at End of Period Col 2 + Col 3 4	Accumulated Depreciation End of Period 5	Net Book Value End of Period Col 4 - Col 5 6	Depreciation this Period 7
1. Land							
2. Buildings							
3. Land Improvements							
4. Leasehold Improvements							
5. Equipment							
6. Transportation							
7. Financing Costs							
8. TOTAL							

NONEXTENSIVE RENOVATIONS

INSTRUCTIONS: Complete for nonextensive renovations in use during cost report period and completed prior to 7/1/05.

ACCOUNT	Cost at Beginning of Period 1	Additions or Reductions 2	Project Cost End of Period Col 2 + Col 3 3	Accumulated Depreciation End of Period 4	Net Book Value End of Period Col 3 - Col 4 5	Depreciation/Amortization this Period 6	Interest this Period 7	Total Columns 6 and 7 8
9. Depreciation/Amortization and Interest								
10. TOTAL								

*** If allocation is used, limit the precision to four places to the right of the decimal

Note: All cost data should be rounded to the nearest whole dollar

QUALIFYING CAPITAL COST INFORMATION - ICF-MR (ONLY)

Schedule B

Provider Name	Medicaid Provider Number	Reporting Period From: _____ Through: _____
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ASSETS ACQUIRED

COST OF OWNERSHIP	Chart of Account	Total	Adjustment Increase (Decrease)	Adjusted Total Col 3 + Col 4	Alloc. ***	Allocated Adjusted Total Col 5 x Col 6
(1)	(2)	(3)	(4)	(5)	(6)	(7)
1. Depreciation - Building	8010					
2. Amortization - Land Improvements	8020					
3. Amortization - Leasehold Improve.	8030					
4. Depreciation - Equipment	8040					
5. Depreciation - Transportation Equip.	8050					
6. Lease and Rent - Building	8060					
7. Lease and Rent - Equipment	8065					
8. Interest Exp. - Prop., Plant and Equip.	8070					
9. Amortization of Financing Costs	8080					
10. Home office Costs/Capital Cost **	8090					
11. TOTAL Cost of Ownership (sum of lines 1 through 10)						

** Home Office Costs are to be entered on line 10 only. They are not to be distributed to any other line in Cost of Ownership.

RENOVATIONS

RENOVATIONS	Chart of Account	Total	Adjustment Increase (Decrease)	Adjusted Total Col 3 + Col]	Alloc. ***	Allocated Adjusted Total Col 5 x Col 6
(1)	(2)	(3)	(4)	(5)	(6)	(7)
12. Depreciation/Amortization and Interest	8500,8570, 8580					
13. TOTAL Renovations						

ANALYSIS OF PROPERTY, PLANT AND EQUIPMENT - ICF-MR (ONLY)

ASSETS ACQUIRED

ACCOUNT	Date Acquired	Cost at Beginning of Period	Additions or Reductions	Cost at End of Period Col 2 + Col 3	Accumulated Depreciation End of Period	Net Book Value End of Period Col 4 - Col 5	Depreciation this Period
	-1	2	3	4	5	6	7
1. Land							
2. Buildings							
3. Land Improvements							
4. Leasehold Improvements							
5. Equipment							
6. Transportation							
7. Financing Costs							
8. TOTAL							

RENOVATIONS

ACCOUNT	Cost at Beginning of Period	Additions or Reductions	Project Cost End of Period Col 2 + Col 3	Accumulated Depreciation End of Period	Net Book Value End of Period Col 3 - Col 4	Depreciation/ Amortization this Period	Interest this Period	Total Columns 6 and 7
	1	2	3	4	5	6	7	8
9. Depreciation/Amortization and Interest								
10. TOTAL								

** Transfer TOTAL of column 8 to "Cost of Ownership" column 3, line 12.

*** If allocation is used, limit the precision to four places to the right of the decimal.

NOTE: All cost data should be rounded to the nearest whole dollar.

Instructions for completing the Ohio department of job and family services (ODJFS) capital compensation cost report for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR).

GENERAL INSTRUCTIONS

OVERVIEW

As a condition to participate in the capital compensation program each NF and ICF-MR shall file a three-month projected capital compensation cost report, hereafter referred to as a “capital compensation cost report” with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of Am. Sub. H.B. 530 of the 126th General Assembly or the date the capital project is completed. The submission deadline for capital projects sixty days after the effective date of H.B. 530 is May 30, 2006. The capital compensation cost report is to be completed in its entirety and must reflect costs related to all assets currently in service, except those assets placed into service after December 31, 2003 that are not related to the qualifying capital program.

Nursing Facilities submitting the cost report for the capital compensation program are to complete pages 1, 2, 3 and 4. In addition, nursing facilities must submit the W-9 IRS Form, “Request for Taxpayer Identification Number and Certification” as well as a complete depreciation and amortization schedule for all assets included on the capital compensation cost report.

Intermediate Care Facilities for the Mentally Retarded submitting the cost report for the capital compensation program are to complete pages 1, 2, 4 and 5. In addition, intermediate care facilities for the mentally retarded must submit the W-9 IRS Form, “Request for Taxpayer Identification Number and Certification” as well as a complete depreciation and amortization schedule for all assets included on the capital compensation cost report.

Submission of the Capital Compensation Cost Report

Providers are to file the capital compensation cost report with the Ohio Department of Job and Family Services, Bureau of Long Term Care Facilities, Reimbursement Section, 30 East Broad Street, 33rd Floor, Columbus, Ohio 43215-3414.

Accounting Basis

Except for county-operated facilities which operate on a cash method of accounting, all providers are required to submit cost data on an accrual basis of accounting. County-operated facilities which utilize the cash method of accounting may submit cost data on a cash basis.

Ohio Cost Report Forms

The Ohio capital compensation cost report is designed to provide statistical data, financial data, and disclosure statements to implement Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly.

Please attach a complete and detailed depreciation and amortization schedule for all assets included on the capital compensation cost report.

Provider Type and Eligibility

Nursing Facilities that are submitting the capital compensation cost report are to indicate their provider type as a nursing facility, and must provide information establishing a qualifying capital activity. A qualifying capital activity must satisfy one of the following:

Section 606.18.06 (B)(1):

A nursing facility that meets both of the following criteria:

1. Both of the following occurred during fiscal years 2006 or 2007:
 - (a) The facility obtained certification as a nursing facility from the Director of Health;
 - (b) The facility began participating in the program.
2. An application for a certificate of need for the nursing facility was filed with the Director of Health before June 15, 2005.

Section 606.18.06 (B)(3):

A nursing facility that meets all the following criteria:

1. The nursing facility does not qualify pursuant to Section 606.18.06 (B)(1).
2. The nursing facility, before June 30, 2007 completes a capital project for which a certificate of need was filed with the Director of Health before June 15, 2005, and for which at least one of the following occurred before July 1, 2005, or, if the capital project is undertaken to comply with rules adopted by the Public health council regarding resident room size or occupancy, before June 30, 2007.
 - (a) any materials or equipment for the capital project delivered,

- (b) preparations for the physical site of the capital project, including if applicable, excavation, began;
 - (c) actual work on the capital project began.
3. The costs of the capital project are not fully reflected in the capital costs portion of the nursing facility's reimbursement per diem rate on June 30, 2005
 4. The nursing facility files a three-month projected capital cost report with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly or the date the capital project is completed.

Section 606.18.06 (B)(5):

A nursing facility that before June 30, 2007 completes an activity to which all of the following apply:

1. A request was filed with the Director of Health before July 1, 2005, for a determination of whether the activity is a reviewable activity and the Director determined that the activity is not a reviewable activity.
2. At least one of the following occurred before July 1, 2005, or, if the nursing facility undertakes the activity to comply with rules adopted by the Public Health Council regarding resident room size or occupancy, before June 30, 2007.
 - a. any materials or equipment for the activity were delivered,
 - b. preparations for the physical site of the activity, including, if applicable, excavation, began
 - c. actual work on the activity began.
3. The costs of the activity are not fully reflected in the capital costs portion of the nursing facility's reimbursement per diem rate on June 30, 2005.
4. The nursing facility files a three month projected capital cost report with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly or the date the activity is completed.

Section 606.18.06 (B)(6)

A nursing facility that before June 30, 2007, completes a renovation to which all of the following apply:

1. The Director of Job and Family Services approved the renovation before July 1, 2005;
2. At least one of the following occurred before July 1, 2005, or if the facility undertakes the renovation to comply with rules adopted by the Public Health Council regarding resident room size or occupancy, before June 30, 2007:
 - a. any materials or equipment for the renovation were delivered,
 - b. preparations for the physical site of the renovation, including, if applicable excavation, began
 - c. actual work on the renovation began.
3. The costs of the renovation are not fully reflected in the capital costs portion of the facility's reimbursement per diem rate on June 30, 2005.

4. The facility files a three month projected capital cost report with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly or the date the renovation is completed.

Intermediate care facilities for the mentally retarded that are submitting the capital compensation cost report are to indicate their provider type as an intermediate care facility for the mentally retarded, and must provide information establishing a qualifying capital activity. A qualifying capital activity must satisfy one of the following:

Section 606.18.06 (B)(2)

An ICF-MR that meets both of the following criteria:

1. Both of the following occurred during fiscal years 2006 or 2007;
 - a. The facility obtained certification as an intermediate care facility for the mentally retarded from the Director of Health.
 - b. The facility began participating in the program
2. At least one of the following occurred before June 30, 2005.
 - a. any materials or equipment for the facility that were delivered,
 - b. preparations for the physical site of the facility, including, if applicable excavation, began
 - c. actual work on the facility began.

Section 606.18.06 (B)(4):

An ICF-MR that meets all of the following criteria:

1. The ICF-MR does not qualify pursuant to Section 606.18.06 (B)(2).
2. The ICF-MR before June 30, 2007 completes a capital project for which at least one of the following occurred before July 1, 2005:
 - a. any materials or equipment for the capital project delivered,
 - b. preparation for the physical site of the capital project including, if applicable, excavation began
 - c. actual work on the capital project began.
3. The costs of the capital project are not fully reflected in the capital costs portion of the ICF-MR's reimbursement per diem rate on June 30, 2005.
4. The ICF-MR files a three month projected capital cost report with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly or the date the capital project is completed.

Section 606.18.06 (B)(6)

An ICF-MR that before June 30, 2007, completes a renovation to which all of the following apply:

1. The Director of Job and Family Services approved the renovation before July 1, 2005;
2. At least one of the following occurred before July 1, 2005, or if the facility undertakes the renovation to comply with rules adopted by the Public Health Council regarding resident room size or occupancy, before June 30, 2007.

- a. any materials or equipment for the renovation were delivered,
 - b. preparations for the physical site of the renovation, including, if applicable excavation, began
 - c. actual work on the renovation begun.
3. The costs of the renovation are not fully reflected in the capital costs portion of the facility's reimbursement per diem rate on June 30, 2005.
 4. The facility files a three month projected capital cost report with the Director of Job and Family Services not later than sixty days after the later of the effective date of Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly or the date the renovation is completed.

Facility Identification

IRS Form W-9, "Request for Taxpayer Identification Number and Certification" – is to be submitted with each cost report.

Provider Name (DBA) – Enter the "doing business as" (DBA) name of the facility as it appears on the provider agreement.

National Provider Identifier (NPI) – Enter the NPI if available. The transition from existing health care provider identifiers to NPIs in standard transactions will occur over the next couple of years. Health care providers could begin applying for an NPI beginning on May 23, 2005. While the NPI must be used on standard transactions with health plans, other than small health plans, no later than May 23, 2007, health care providers should not begin using the NPI in standard transactions on or before the compliance dates until health plans have issued specific instructions on accepting the NPI. Ohio will notify you when you can begin using NPIs in standard transactions. Applying for an NPI does not replace any enrollment or credentialing processes with .

Provider Number – Enter the seven digit provider number as it appears on the provider agreement.

Provider Number – Enter the six digit provider number furnished by the Ohio Department of Health (ODH) or the CMS. numbers are assigned to each facility regardless of the facility's certification status. The number also appears on the provider agreement.

Complete Facility Address – Enter the contact person's name and address of the facility. Include city and ZIP code where the facility is physically located.

Federal ID Number – Enter the Federal Tax Identification Number as it is reported to the United States Internal Revenue Service.

ODH ID Number - Enter the Ohio Department of Health (ODH) 4-digit home number, also referred to by ODH as the "Fac ID" Number.

County – Enter the Ohio county in which the facility is physically located.

Period Covered by the Cost Report

The period covered by the capital compensation cost report is the three month period beginning when the project was placed into service.

Program Eligibility Dates

The program eligibility dates are to be completed per instructions on the form.

Cost Report Schedules

The provider must complete the information requested. Responses such as “Not Applicable,” “N/A,” “Same as Above,” “Available upon request,” or “Available at the time of Audit”, will result in the cost report being deemed incomplete or inadequate. An incomplete or inadequate cost report may result in a denial of payments pursuant to Section 606.18.06 of the Am. Sub. H.B. 530 of the 126th General Assembly. The provider will be required to submit to ODJFS the information required to complete the cost report prior to the provider receiving payments

Table of Cost Report Schedules

<u>Report Schedules</u>	<u>Title</u>	<u>Page Number</u>
Schedule A	Qualifying Capital Costs Info. – Nursing Facility	Page 3
Schedule B	Qualifying Capital Costs Info. – ICF-MR	Page 4

Cost Report Instructions

- All expenses are to be rounded to the nearest dollar.
- All dates should contain eight digits and be formatted as follows: Month-Day-Year (MM-DD-YYYY)
- All date fields are denoted as From/Through or Beginning/End.

Example: January 1, (20CY) should be recorded as 010120CY (zero, one, zero, one, 20CY)

All Patients – Statistical Data

Lines 1 and 2: Licensed beds:

Enter the total number of beds licensed by ODH in column 2. Enter the total number of beds licensed by ODH and certified by in column 1. Temporary changes because of alterations, painting, etc. do not affect bed capacity.

Line 3: Total Bed Days:

For column 1, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH and certified by during the reporting period. Take into account increases or decreases in the number of beds licensed and certified and the number of days elapsed since the increase or decrease in licensed and certified beds.

For column 2, this amount is determined by multiplying the number of days in the reporting period by the number of beds licensed by ODH during the reporting period. Take into account increases or decreases in the number of beds licensed and the number of days elapsed since the increases or decreases.

Line 4: Total Inpatient Days:

For column 1, enter the total number of inpatient days for the facility for all certified beds only, for column 2, enter the total number of inpatient days for the facility for all ODH licensed beds.

Line 5: Percentage of Occupancy:

This amount is the proportion of total inpatient/resident days to total bed days during the reporting period. Obtain the answer by dividing line 4 by line 3.

Capital Cost Center – Nursing Facilities (Only)

The capital costs for nursing facilities (NFs) means the actual expense incurred for all of the following:

- Depreciation and interest on any capital asset with a cost of five hundred dollars or more per item and a useful life of at least two (2) years. Provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the five hundred dollars criteria be exceeded.
 - (1) Buildings;
 - (2) Building improvements
 - (3) Equipment;
 - (4) Extensive renovations;
 - (5) Transportation equipment;
- Amortization and interest on land improvements and leasehold improvements;
- Amortization of financing costs;
- Lease and rent of land, building, and equipment that does not qualify for account 7740 leased equipment.

Analysis of Property, Plant and Equipment – Nursing Facilities

This section is to be completed per instructions on the form.

Capital Cost Center – ICFs-MR (Only)

This section is to be completed per instructions on the form.

The cost of ownership for ICFs-MR means the actual expense incurred for all of the following:

- Depreciation and interest on any capital asset with a cost of five hundred dollars or more per item and a useful life of at least two (2) years. Provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the five hundred dollars criteria be exceeded.
 - (1) Buildings;
 - (2) Building improvements that are not approved as nonextensive renovations under section 5111.25 or 5111.251 of the Revised Code;
 - (3) Equipment;
 - (4) Extensive renovations;
 - (5) Transportation equipment;
- Amortization and interest on land improvements and leasehold improvements;
- Amortization of financing costs;
- Lease and rent of land, building, and equipment that does not qualify for account 7400 leased equipment.

Analysis of Property, Plant and Equipment – ICFs-MR

This section is to be completed per instructions on the form.

Certification by Officer of Provider:

All cost reports submitted by the provider must contain a completed certification signed by an administrator, owner, or responsible officer. The original signature must be notarized.

If the cost report preparer is a company, complete the "Report Prepared by (Company)" line only. If the cost report is completed by an individual, complete the "Report Prepared by (Individual)" line only.