

## INSTRUCTIONS FOR FILING LONG-TERM CARE FACILITY COST REPORT

### Instructions

The cost reporting forms and schedules described below must be used by all Mississippi long-term care facilities participating in the Mississippi Medicaid Program (Title XIX). Medicare (Title XVIII) cost reporting forms are not acceptable in lieu of these forms. Hospital based facilities and state-owned facilities which use the Medicare forms for step-down in completing their cost report must submit a copy of the applicable Medicare cost report forms. The Medicaid long-term care facility cost report forms must be submitted in an Excel format utilizing the Long-Term Care Facility Cost Report Forms - Integrated Excel spreadsheet available on the Mississippi Division of Medicaid website. <https://medicaid.ms.gov/resources/forms/>

### General Information

These instructions are for use in the preparation and submission of the cost report to the Division of Medicaid (DOM) by all Mississippi long-term care facilities providing care and services under the Medical Assistance Program, including nursing facilities (NF), intermediate care facilities for individuals with intellectual disabilities (ICF-IID) and psychiatric residential treatment facilities (PRTF).

The annual reports are the basis for determining reimbursement rates. A copy of all reports and statistical data must be retained by the facility for no less than three years following the date reports are submitted to the Division of Medicaid. **All dollar amounts must be rounded to the nearest dollar and must foot and cross-foot. Only per diem cost amounts will not be rounded.** Cost reports submitted that have not been rounded in accordance with this policy will be returned to the provider and will not be considered as received until they are re-submitted. **Do Not input facility or other names in all capital letters.**

### Annual Reporting

Reports are to be filed with the Division of **Medicaid's agent** on or before the last day of the fifth month following the close of the provider's reporting period. Should the due date fall on a Saturday, Sunday, State of Mississippi holiday or federal holiday, the due date shall be the following business day.

**The cost reports must be uploaded to the database developed by the Division's agent at the MSLC Portal <https://MississippiCostReports.mslc.com>: Each facility or their agent must be registered to access this portal. Cost reports will not be accepted in hard copy form.**

The following documentation must be submitted with the cost reports **and uploaded to the portal as well:**

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- (a) Working trial balance(s) of all entities reported on the cost report forms with the appropriate cost report line numbers, including approved ventilator dependent (VDC) patient services, to which each account can be traced. This should be done by running a trial balance in cost report line number order that subtotals the accounts by cost report line number. The subtotals should tie to each cost report line. A grouping schedule of the trial balance that ties to each line of Form 5, Form 6 and Form 11 must be submitted.
- (b) Depreciation schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted. If the facility has home office costs, a copy of the home office depreciation schedule must also be submitted. All hospital-based facilities must submit a separate depreciation schedule that clearly shows and totals assets that are (1) hospital only, (2) NF only and (3) shared assets. For the depreciation schedule with the shared assets, an allocation of the cost and depreciation applicable to the nursing facility is required. **If the provider is expensing assets less than \$5,000 that were capitalized for financial purposes, a separate Medicaid only schedule must be submitted with these expensed assets removed.** All Medicaid-basis facility depreciation schedules must be sorted by the asset categories on Form 7 and subtotaled by year of acquisition.
- (c) Amortization schedule(s), if applicable.
- (d) Narrative description of purchased management services or a copy of contracts for managed services, if applicable.
- (e) A description of the basis used to allocate the home office or related management company costs to providers of the group and to non-provider activities, if applicable, and a copy of the cost allocation worksheets.
- (f) Hospital-based and state facilities must submit all allocation worksheets. A grouping schedule of the trial balance that ties to each line of Worksheet A must be submitted. The Medicare schedules that must be submitted for facilities using the Medicare forms for allocation are: Worksheet A, Reclassification and Adjustment of Trial Balance of Expenses; Worksheet A-6, Reclassifications; Worksheet A-7, Capital Analysis and Reconciliation; Worksheet A-8, Adjustments to Expenses; Worksheet A-8-1, Statement of Costs of Services from Related Organizations; Worksheet B, Part 1, Cost Allocation - General Service Costs; Worksheet B, Part II, Allocation of Capital Related

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Costs and Worksheet B-1, Cost Allocation - Statistical Basis.

- (g) When reporting Respiratory Therapy expenses (salaries, contract costs, benefits) in Section 2 of Form 6, provide a recap showing the breakdown of Respiratory Therapy expense versus other expenses reported on each line.

Cost reports must be submitted on or before the due date in order to avoid a penalty in the amount of \$50.00 per day each day the cost report is delinquent. The submission date will be verified by postmark, delivery ticket, or date hand delivered.

When it is determined that a cost report does not include the checklist, all required forms and schedules, and documentation listed in items (a) through (f) of this section, the provider will be notified. The provider must submit a complete cost report. If the request is made and the completed cost report is not received on or before the due date of the cost report or is not received within 24 hours of the request if made after the due date, the provider will be subject to the penalties for filing delinquent cost reports.

When it is determined that additional information is needed, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made and five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted and be considered for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of financial review, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made.

Allowable costs will be adjusted to disallow any expenses or cost findings that are not submitted.

### Accounting Basis

The report must be prepared on the accrual basis of accounting. If a facility is on a

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cash basis, it will be necessary to convert from cash to an accrual basis for reporting purposes. This does not apply to governmental facilities.

Particular attention must be given to an accurate accrual of all costs at the end of the reporting period for the equitable distribution of costs to the applicable period. Care must be given to the proper allocation of costs for service and maintenance contracts to the period covered by such contracts. Care should be given to a proper cutoff of accounts receivable and accounts payable both at the beginning and ending of the reporting year. Amounts earned although not actually received and amounts owed to creditors but not paid must be included in the reporting period.

### **Supporting Information**

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. The report is based on financial and statistical records which must be maintained by the facility for three (3) years from the date submitted to the Division of Mississippi. Cost information must be current, accurate, and in sufficient detail to support the claim for reasonable cost-related reimbursement. This includes all ledgers, journals, records, and original evidence of costs (canceled checks, purchase orders, invoices, vouchers, inventories, timecards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. Census data on the cost report must be supported by daily census records, patient's charts, etc. Such information must be adequate and available for auditing.

### **Amended Cost Reports**

The Division of Medicaid accepts amended cost reports for a period of thirty-six (36) months following the end of the reporting period. Form 1, Section II must be completed on all amended cost reports in order to explain the reason for the amendment. Form 2 with an original signature certifying that the amended information is correct, and all amended supporting related information must be submitted. Each form and schedule submitted must be clearly marked "Amended". Amended cost reports submitted after the annual base rate is determined will be used only to adjust the individual provider's rate, if necessary. Amended cost reports will not be accepted for the following: a) on or after the date that Medicaid financial review field work begins, b) to submit additional information for costs previously disallowed due to failure to respond to a request for information, or c) for submission of detailed expense descriptions for which costs were disallowed because non-acceptable descriptions were used.

### **Instructions for Cost Report Forms**

#### **CHECKLIST**

Complete, sign and submit the checklist. Check "YES" or "N/A" for all items. All items

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marked “YES” must be submitted with the cost report.

When it is determined in accordance with cost report instructions that certain form(s) and schedule(s) are not required to be filed, the “N/A” column should be checked. The items marked “N/A” in accordance with cost report instructions do not have to be submitted.

Where appropriate “Incomplete” error messages may appear. Please correct all errors causing “Incomplete” errors prior to submission. Cost reports submitted with “Incomplete” errors may be rejected.

### **FORM 1      GENERAL INFORMATION**

**I.      Facility Name:**

The name of the long-term care facility as licensed by the Mississippi State Department of Health.

**Provider Number:**

The facility's Medicaid provider number in effect for the dates of the cost report.

**D/B/A:**

The name by which the long-term care facility operates (complete only if different from facility name above).

**Administrator, MS License Number:**

The facility's administrator at the close of the cost reporting period.

**E-Mail Address:**

Enter the facility e-mail address, if available, Administrator or contact person

**Contact Person:**

The person who should be contacted regarding the cost report.

**All Correspondence and Desk Reviews Regarding This Cost Report Should Be Addressed To (Limited to one name and address):**

List the name, address, telephone number and fax number of the person to whom all correspondence, desk reviews, financial reviews, etc. should be addressed. Each facility is allowed only one name and address in this section.

**II.      Complete this section only if the facility is filing an amended cost report.**

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The reason for the amendment must be clearly stated and each cost report form being amended must be marked "**AMENDED**" at the top of each form. Each amended cost report must include Forms 1 and 2 as well as the applicable forms and schedules being amended.

- III. Complete this section if the General Ledger of the Medicaid-certified nursing facility also accounts for other entities. Examples of other entities are hospital, rural health clinic, outpatient therapy services, non-Medicaid certified nursing facility, and personal care home.
- IV. Complete this section only if the facility has a home office/related management company. In addition, facilities claiming home office costs/related management fees must complete Form 17 and Schedules 11 and 12. Facilities with a home office must also complete Form 18.
- V. Complete this section if the facility employs a management company. A narrative description of purchased management services or a copy of contracts for managed services must be submitted with the cost report in order for management fees to be allowed.
- VI. For DOM use only.

### FORM 2 CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

The Certification by Officer or Administrator of Provider is required and must be signed by an authorized officer or the administrator of the facility. The cost report will not be deemed received by the Division of Medicaid if this certification has not been completed.

The cost report may be completed by the facility's employees, owners, independent accountants, or other qualified parties. The name and address of the preparer as well as the name and telephone number of a contact person must be completed on Form 2.

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**FORM 3      STATISTICAL DATA**

**Lines 1, 2, 3 and 4**

Please check the appropriate blocks that apply to your facility. Please check only one block on each of lines 1, 3, and 4. Line 2 must have a box checked on each of lines A, B and C.

A facility is part of a chain if the facility owner(s) also owns another one or more separate long-term care facilities.

A hospital-based nursing facility is defined as a nursing facility that is either physically located in a hospital or is owned or controlled by a hospital and all of the nursing facility costs are included in the hospital's Medicare cost report and the nursing facility receives overhead allocated from the hospital.

Please check blocks on Line 2.D), Column 1 so that all entity types reported in the general ledger are marked "Yes". Note that line 1.a must be completed for facilities approved for ventilator dependent (VDC) patient services. Columns 2, 3, 4 and 5 must be completed if "Yes" is marked in Column 1.

- |          |   |
|----------|---|
| Column 1 | Check "Yes" if the entity type is reported in the general ledger.   |
| Column 2 | Enter the number of patient days related to the particular use of the facility.   |
| Column 3 | Enter the number of beds related to the particular use of the facility.   |
| Column 4 | Enter the square footage related to the particular use of the facility.   |
| Column 5 | Enter the shared square footage related to the particular use of the facility. If square footage is reported in this column, attach detail which explains with which area the square footage is shared and by how much. |

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Enter the total square footage of the facility on Line 2.E).

**Line 5**

Complete the number of patient days by type of patient. Include only statistics for Medicaid-certified beds. Do not include statistics for personal care beds, for example. Column (A) Total Patient Days, Column (B) Medicaid Patient Days, Column (C) Medicare Patient Days, Column (D) Private Pay Patient Days, Column (E) Other – all other patient days.

Holding and leave days are to be included in patient days. Residents of long-term care facilities are considered Medicaid-only when Medicaid is the primary payer for that day. For example, if a resident is Medicare/Medicaid, the days that Medicaid pays the Medicare co-insurance are counted as Medicare days for statistical purposes.

**Lines 6, 7a.–7c., and 8**

Enter the number of beds certified for Medicaid at the beginning of the period on Line 6 in the second block. If the beginning certified beds changed from the previous period end, show the effective date of the change in the number of beds in the first block of Line 6. If there was no change in the number of Medicaid-certified beds during the cost report period, enter the ending number of beds in the second block of Line 8. Temporary changes because of alterations, repairs, etc. do not affect bed capacity. Show any changes to the number of Medicaid-certified beds in the second block of Lines 7a., 7.b and 7c. Show the effective date of each of those changes in the first block of those Lines.

**Line 9**

The total certified bed days available during the period is automatically calculated by multiplying the number of beds available for the period by the number of days in the period. Any increase or decrease in the number of beds is taken into consideration as well as the number of days elapsed during each increase or decrease.

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**Line 10**

The percentage of occupancy for the cost report period should be computed by dividing the total patient days from Line 5, Column A by the bed days available on Line 9. This number must be rounded to two (2) decimal places (example: 98.57%)

**Line 11**

The percentage of Medicaid utilization is the total Medicaid days from Line 5, Column B divided by the total patient days from Line 5, Column A. This number must be rounded to two (2) decimal places (Example: 78.94%).

**FORM 4     PATIENT DAY STATISTICS**

**SECTION I**

Include only statistics for Medicaid-certified beds in this section. Do not include non-Medicaid certified beds statistics on Form 4 (example: personal care beds).

Residents of long-term care facilities are considered Medicaid-only when Medicaid is the primary payer for that day. For example, if a resident is Medicare/Medicaid, the days in which Medicaid pays the Medicare co-insurance would be considered Medicare days for statistical purposes.

Holding and leave days are to be included in patient days. Data for months 13 through 15 in the cost reporting period must be combined and reported with the twelfth month's data.

**Column 1**    The calendar month for each month in the cost reporting period will automatically populate once the cost report begin and end dates are entered on Form 1. If necessary, these months may be overridden. Each month in the reporting period **MUST** be entered.

**Column 2**    List the Medicaid patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column B.

**Column 3**    List Medicare patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column C.

**Column 4**    List private pay patient days for the reporting period by month. The total of this column must agree with Form 3, Line 5, Column D.

**Column 5**    List all other types of patient days for the reporting period by month. The

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total of this column must agree with Form 3, Line 5, Column E.

Column 6     Total of Columns 2, 3, 4, and 5. The total of this column must agree with Form 3, Line 5, Column A.

Column 7     The total number of bed days available for each month is calculated by multiplying the number of certified beds by the number of days in the month. Changes in bed and days applicable related to bed changes are considered. If appropriate, the values in this column may be overridden with the appropriate number of bed days available.

Column 8     Enter the Total Patient Days in Column 6 divided by the Bed Days Available in Column 7 for each line. The percentage must be rounded to two (2) decimal places (Example: 99.75%).

Column 9     List the VDC portion of patient days included in Column 6 for the reporting period by month. The total of this column must agree with Form 3, Line 2.D)1a., Column 2.

**SECTION II.**

List the facility's private pay rates for both private rooms and semi-private rooms. The list should include all rates that were effective during the reporting period.

**SECTION III.**

List the facility's ending private pay rate for both private rooms and semi-private rooms.

**FORM 5     STATEMENT OF REVENUES AND EXPENSES**

All revenue is to be entered on the appropriate line in Column 1 and must agree with the revenue recorded in the general ledger. If the facility has a non-Medicaid certified portion of a facility, the total line-item amounts per the general ledger must be recorded in Column 1. The portion of the line-item amounts from the general ledger that apply to the Medicaid participating portion of the long-term care facility must be recorded in Column 2. Column 2 cannot be blank. Adjustments to the revenue accounts must be entered in Column 3. Enter the line number reference for each adjustment in Column 4.

Revenue cost findings must be submitted on a separate schedule which shows the computation of cost and the basis for the computation. The purpose of a cost finding is to identify costs associated with generating specific revenue. Failure to submit adequate cost findings for other income or the sources and/or uses of contributions, gifts and grants will result in the revenues being offset against cost. A cost finding includes, but is not limited to, direct salaries and fringe benefits, indirect salaries and fringe benefits (ex. billing clerk), contractual fees, consulting fees, supplies, utilities, and capital costs, including property taxes, insurance and depreciation incurred to generate

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the revenue. Cost allocations, when necessary, should be based on Medicare guidelines published in CMS Publication 15-1. All costs identified in the cost findings are non-allowable costs and must be offset against the appropriate line of Form 6, Column 4. Revenue offsets should not create a negative adjusted balance on the referenced cost line of Form 6, Column 5. When the cost finding is not submitted or is incomplete, revenue offsets in excess of referenced costs should be taken to Form 6, Line 4-37, which may have a negative adjusted balance in Column 5.

**Line 1a. Medicare Part A Revenue**

Enter all patient revenues for room and board received for Medicare Part A stays.

This income for the Medicare Part A per diem includes any ancillaries paid for through the per diem rate on line 1.

**Line 1b. Allowances and Discounts on Patients' Accounts**

Enter the allowances and discounts on patients' accounts pertaining to Medicare Part A Revenue. This includes contractual adjustments for revenue reported on Line 1.a. only.

**Line 2a. Medicaid Revenues**

Enter all patient revenues for room and board received for Medicaid stays. Revenues received for items billed outside of the room and board charge (i.e. durable medical equipment, drugs, etc.) for Medicaid stays should be included in the Other Income section of Form 5.

**Line 2b. Allowances and Discounts on Patients' Accounts**

Enter the allowances and discounts on patients' accounts pertaining to Medicaid Revenue. This includes contractual adjustments for revenue reported on Line 2.a. only.

**Line 3a. Other Patient Revenues**

Enter other patient revenues for room and board (for stays other than Medicare or Medicaid). Revenues received for items billed outside of the room and board charge (i.e., durable medical equipment, drugs, etc.) should be included in the Other Income section of Form 5.

**Line 3b. Allowances and Discounts on Patients' Accounts**

Enter the allowances and discounts on patients' accounts pertaining to Other Patient Revenue. This includes contractual adjustments for revenue reported on Line 3.a. only.

**Line 4. Net Patient Revenues**

Lines 1.a., 2.a., and 3.a. less Lines 1.b., 2.b., and 3.b.

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Line 5. Total Operating Expenses

Column 1 must agree with Form 6, Line 7-2, Column 1.

Line 6. Net Income from Services to Patients

Line 4 less Line 5.

**Contractual adjustments related to revenue reported on Lines 7 - 24 must be netted against the related revenue.**

Line 7. Barber and Beauty Income:

Enter all barber and beauty income on this line. Enter an adjustment in Column 3 equal to the amount of the cost. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made first to Form 6, Line 6-03, then Line 3-13. Any excess revenue amounts over cost should be offset against Line 4-37.

Line 8. Contributions, Gifts, Grants, etc.:

Enter all contributions, gifts and grants income on this line. An offset of income against allowable costs is not required for unrestricted contributions, gifts and grants. For restricted contributions, gifts and grants, revenue must be matched to costs and offset against those costs. The source and/or purpose of contributions, gifts and grants must be disclosed when the cost report is submitted.

Line 9. Feeding Assistant Training Reimbursement:

Enter the feeding assistant training reimbursement on this line. All feeding assistant training expense must be reported on Form 6, Line 6-05. Refer to facility records and Division of Medicaid summary reports for expense amounts.

Line 10. Guest and Employee Meals Revenue:

Enter all guest and employee meals revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 3-20.

Line 11. Interest Income:

Enter all interest income on this line. The adjustment entered in Column 3

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should be the lesser of reported interest income or interest expense. Interest income must be offset first against interest expense reported on Form 6, Line 4-33 and then Form 6, Line 5-03.

**Line 12. Nurse Aide Training and Testing Reimbursement:**

Enter the nurse aide training and testing reimbursement on this line. All nurse aide training and testing expense must be reported on Form 6, Lines 6-09 and 6-10. Refer to facility records and Division of Medicaid summary reports for expense amounts.

**Line 13. Nursing Supplies:**

Enter all nursing supplies revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 1-15, then Line 1-17.

**Line 14. Other Ancillary Services Revenue Including Medicaid Crossover Payments:**

Enter all ancillary services revenue (ex. durable medical equipment) which is not more appropriately reported on another line of Form 5. Oxygen (Inhalation Therapy) Revenue should also be reported on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 1 or Form 6, Section 2 depending on the provider's reporting of oxygen expense. If reported in both places the offset should be to Section 1 first and then Section 2.

**Line 15. Other Income:**

Enter all income on this line which is not more appropriately reported on another line. All income must be listed on Schedule 1. Enter an adjustment in Column 3 for the amount of the cost findings. If the facility does not submit cost findings with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to lines on Form 6 as deemed appropriate.

**Line 16. Occupational Therapy Income:**

Enter all occupational therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-.

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**Line 17. Pharmacy Revenue:**

Enter all pharmacy revenue on this line. A revenue offset is not required for pharmacy revenue. Instead, the criteria for determining allowable pharmacy expenses on the cost report should be followed.

**Line 18. Physical Therapy Income:**

Enter all physical therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

**Line 19. Rental Income:**

Enter all rental income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Lines 5-02, 5-03, 5-04, 5-05 and any remaining balance to line 4-37.

**Line 20. Respiratory Therapy Income:**

Enter all respiratory therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 19, if applicable, and then to Form 6, Section 2. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

**Line 21. Speech Therapy Income:**

Enter all speech therapy income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Section 2 of the cost report. If there is not enough expense reported in Section 2, adjust the remainder to Form 6, Line 3-19.

**Line 22. State Appropriations:**

Enter all state appropriations on this line. No offset is required.

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Line 23. Television, Telephone Income:

Enter all television and telephone income on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Lines 6-14 and 4-46 for television and to Line 4-44 for telephone.

Line 24. Vending Machines Revenue:

Enter all vending machines revenue on this line. Enter an adjustment in Column 3 for the amount of the cost finding. If the facility does not submit a cost finding with the cost report, enter the total amount of revenue in Column 3 and deduct the total amount of revenue from allowable costs. Offsets of allowable costs without a cost finding must be made to Form 6, Line 6-15 and then Line 4-46. However, if the revenue is from commissions only, no offset of revenue is required.

Line 25. The sum of Lines 7 through 24.

Line 26. The sum of Lines 6 and 25. Line 26 must agree with Form 12, Line 1.

**FORM 6      SCHEDULE OF EXPENSES**

Column 1      Enter the expenses per the general ledger on the appropriate line. Line 7-2 of this column must agree with Form 5, Line 5. **This column must agree with the trial balance included with the cost report.**

Column 2      This column is for any reclassification that should be made between expenses. For example, all costs not associated with the Medicaid-certified portion of the Long-term Care Facility must be reclassified in Column 2 to Line 6-08, Non-Medicaid Long-term Care Costs. The total for Column 2 on Line 7 must be zero. A schedule must be attached to describe any reclassifications made and the calculation of the amounts being reclassified.

Facilities which have a portion of the facility that is not certified for Medicaid must allocate the costs associated with that portion of the facility as non-allowable costs. These costs must be allocated based on square footage for fixed costs (i.e., utilities, depreciation, interest), actual salaries and fringe benefits of employees working in the non-certified area and based on patient days for non-direct costs (i.e., administrative costs, dietary costs), or other methods which are acceptable by Medicare per CMS Publication 15-1 guidelines.

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Column 3     Column 1 plus or minus Column 2.

Column 4     Adjustments to expenses must be entered in Column 4. These adjustments should include excess owner's compensation, excess related party expenses, excess dues, excess owner's relatives' compensation, excess board of directors' fees, revenue offsets, etc. A schedule must be attached to describe any adjustments made and the calculation of the amounts being adjusted.

Column 5     Column 3 plus or minus Column 4. Form 6 must foot and cross-foot. All problems with rounding must be corrected before the cost report is submitted.

Line 1 Direct Care Expenses

Costs of the direct care of medical services must be included in Section 1, Line 1-01 through 1-18. Lines 1-05 through 1-10 are employee benefits for the direct care employees.

Line 1-01, Salaries-Aides

Gross salary of certified nurse aides and nurse aides in training.

Line 1-02, Salaries-LPN's

Gross salaries of licensed practical nurses and graduate practical nurses.

Line 1-03, Salaries-RN's (exclude DON and RAI Coordinator)

Gross salaries of registered nurses and graduate nurses (excluding the DON and Resident Assessment Instrument Coordinator).

Line 1-04, Salaries-Feeding Assistants

Gross salary of feeding assistants.

Line 1-05, FICA-Direct Care

Cost of employer's portion of Social Security Tax and Medicare for direct care employees.

Line 1-06, Group Insurance-Direct Care

Cost of employer's contribution to employee health, life, accident and disability insurance for direct care employees.

Line 1-07, Pensions-Direct Care

Cost of employer's contribution to employee pensions for direct care

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employees.

Line 1-08, Unemployment Taxes-Direct Care

Cost of employer's contribution to State and Federal unemployment taxes for direct care employees.

Line 1-09, Uniform Allowance-Direct Care

Employer's cost of uniform allowance and/or uniforms for direct care employees.

Line 1-10, Workmen's Comp-Direct Care

Cost of workmen's compensation insurance for direct care employees.

Line 1-11, Contract-Aides

Cost of aides hired through contract who are not facility employees.

Line 1-12, Contract-LPN's

Cost of LPN's and graduate practical nurses hired through contract who are not facility employees.

Line 1-13, Contract-RN's

Cost of RN's and graduate nurses hired through contract who are not facility employees.

Line 1-14, Drugs-Over-the-Counter and Legend

If a drug is covered by the Medicaid program, the cost of the drug is not allowable on the cost report for any resident, regardless of payor source (Medicaid, Medicare Part A, private, VA). In addition, if a drug is in a class eligible for payment by a Medicare Part D plan and the resident is or could be eligible to receive Part D benefits, the cost of the drug is non-allowable on the cost report. Accordingly, if a drug is provided to a non-Medicaid resident (Medicare Part A or private) and would be covered by Medicaid or Medicare Part D if the resident were in a Medicaid stay, the related cost is not allowable on the cost report.

The cost of bulk drug purchases of over-the-counter drugs (stock drugs) for distribution to any facility resident is allowable on the cost report Line 1-14.

Non-allowable drug costs must be reported on or reclassified to Line 6-13.

Line 1-15, Medical Supplies-Direct Care

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Cost of patient-specific items of medical supplies such as catheters, syringes and sterile dressings.

Line 1-16, Medical Waste Disposal

Cost of medical waste disposal including storage containers and disposal costs.

Line 1-17, Other Supplies-Direct Care

Cost of items used in the direct care of residents that are not patient-specific such as prep supplies, alcohol pads, Betadine solution in bulk, tongue depressors, cotton balls, thermometers, and blood pressure cuffs. Costs related to nursing equipment, either rented or purchased, or the repairs to, or maintenance of, nursing equipment should not be included on this line but rather in the appropriate line in Section 4 or 5.

Line 1-18, Salaries – Respiratory Therapists

Gross salaries of respiratory therapists. Do not include salary costs for Respiratory Therapists reported on Form 19.

Line 1-19, Benefits – Respiratory Therapists

Include all FICA, group insurance, pension, unemployment taxes, and workmen's compensations costs applicable to the salaries reported on Line 1-18. Do not include FICA, group insurance, pension, unemployment taxes, uniforms or workmen's compensation costs for Respiratory Therapists reported on Form 19.

Line 1-20, Contract – Respiratory Therapists

Cost of respiratory therapists hired through contract who are not facility employees. Do not include contract costs for Respiratory Therapists reported on Form 19.

Line 1-21, Allocated Costs-Hospital Based and State Facilities (net of capital costs)

Direct Care costs that have been allocated through the step-down process from a hospital or State institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs on this line must complete Schedule 2 and Schedule 13.

Line 1-22, Total Direct Care Costs

Line 1-22 is the sum of Line 1-01 through Line 1-21.

Line 2 Therapy Expenses

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Costs attributable to the administering of therapy services must be included in Section 2, Lines 2-01 through 2-16. Lines 2-05 through 2-10 are employee benefits for therapy salaries.

Line 2-01, Salaries-Occupational Therapists  
Gross salaries of occupational therapists.

Line 2-02, Salaries-Physical Therapists  
Gross salaries of physical therapists.

Line 2-03, Salaries-Speech Therapists  
Gross salaries of speech therapists.

Line 2-04, Salaries-Other Therapists  
Gross salaries of therapists other than occupational therapists, physical therapists, speech therapists, or respiratory therapists. Report Respiratory Therapist salaries on Line 2-16.

Line 2-05, FICA-Therapies  
Cost of employer's portion of Social Security Tax and Medicare for therapy employees included in Lines 2-01 through 2-04 above. Report FICA for Respiratory Therapists on Line 2-17.

Line 2-06, Group Insurance-Therapies  
Cost of employer's contribution to employee health, life, accident and disability insurance for therapy employees reported on Lines 2-01 through 2-04 above. Report Group insurance costs for Respiratory Therapists on Line 2-17.

Line 2-07, Pensions-Therapies  
Cost of employer's contribution to employee pensions for therapy employees reported on Lines 2-01 through 2-04 above. Report Pension costs for Respiratory Therapists on Line 2-17.

Line 2-08, Unemployment Taxes-Therapies  
Cost of employer's contribution to State and Federal unemployment taxes for therapy employees reported in Lines 2-01 through 2-04 above. Report unemployment tax costs for Respiratory Therapists on Line 2-17.

Line 2-09, Uniform Allowance-Therapies  
Employer's cost of uniform allowance and/or uniforms for therapy employees. Report uniform allowance costs for Respiratory

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Therapists reported on Line 2-17.

**Line 2-10, Workmen's Comp-Therapies**

Cost of workmen's compensation insurance for therapy employees. Report Workmen's Comp costs for Respiratory Therapists reported on line 2-17.

**Line 2-11, Contract-Occupational Therapists**

Cost of occupational therapists hired through contract who are not facility employees.

**Line 2-12, Contract-Physical Therapists**

Cost of physical therapists hired through contract who are not facility employees.

**Line 2-13, Contract-Speech Therapists**

Cost of speech therapists hired through contract who are not facility employees.

**Line 2-14, Contract-Other Therapists**

Cost of therapists other than occupational therapists, physical therapists, speech therapists and respiratory therapists hired through contract that are not facility employees. Report contracted respiratory therapists on Line 2-18.

**Line 2-15, Therapy Costs - Other**

All other costs incurred for rendering direct therapeutic service to the residents of the facility, including but not limited to dues, educational seminars and training, licenses, supplies and travel. Non-direct costs, i.e. attendance at seminars not directly related to rendering therapeutic services and related travel expense, should be reported in Section 4 of Form 6.

**Line 2-16, Allocated Costs-Hospital Based and State Facilities (net of capital costs)**

Therapy costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 2, Schedule 3 and Schedule 13.

**Line 2-17, Total Therapy Costs**

Line 2-17 is the sum of Line 2-01 through 2-16.

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Line 3 Care Related Expenses

Care related services include activities, director and assistant director of nursing, medical director, pharmacy, and social services. Employee benefits for these salaries must be included on Lines 3-07 through 3-12. Supplies for care related services and certain personal hygiene items must be included on Line 3-21.

Line 3-01, Salaries-Activities

Gross salaries of personnel providing an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interest and the physical, mental, and psychosocial well-being of the residents.

Line 3-02, Salaries-Assistant Director of Nursing

Gross salary of the Assistant Director of Nursing.

Line 3-03, Salaries-Director of Nursing

Gross salary of the Director of Nursing.

Line 3-04, Salaries-Resident Assessment Instrument Coordinator

Gross salary of the Resident Assessment Instrument Coordinator.

Line 3-05, Salaries-Pharmacy

A portion of pharmacy salaries is allowable based on an allocation of prescriptions dispensed that represent allowable drug costs on Line 1-14 to total drugs dispensed by the pharmacy. The allocation calculation must be enclosed with the cost report. Pharmacy salaries will not be allowable related to bulk drug purchases.

Allocation calculation example: A hospital pharmacy related to a hospital-based nursing facility prepared 300,000 prescriptions during the cost report period. Of these, 36 prescriptions were dispensed for which the related costs are allowable on the nursing facility cost report Line 1-14. No other prescriptions dispensed for nursing facility residents are allowable on Line 1-14. The pharmacy salaries total \$100,000. The allowable allocation of pharmacy salaries is \$12, calculated as follows:  $36 / 300,000 * \$100,000$ .

Line 3-06, Salaries-Social Services

Gross salaries of personnel providing medically related social services to attain or maintain the highest practicable physical, mental or psychosocial well-being of the residents.

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Line 3-07, FICA-Care Related

Cost of employer's portion of Social Security Tax and Medicare for care related employees.

Line 3-08, Group Insurance-Care Related

Cost of employer's contribution to employee health, life, accident and disability insurance for care related employees.

Line 3-09, Pensions-Care Related

Cost of employer's contribution to employee pensions for care related employees.

Line 3-10, Unemployment Taxes-Care Related

Cost of employer's contribution to State and Federal unemployment taxes for care related employees.

Line 3-11, Uniform Allowance-Care Related

Employer's cost of uniform allowance and/or uniforms for care related employees.

Line 3-12, Workmen's Comp-Care Related

Cost of workmen's compensation insurance for care related employees.

Line 3-13, Barber and Beauty Expense - Allowable

The cost of barber and beauty services provided to residents for which no charge is made.

Line 3-14, Consultant Fees-Activities

Fees paid to activities personnel, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-15, Consultant Fees-Medical Director

Fees paid to a medical doctor, not on the facility payroll, for providing advisory, educational and emergency medical services to the facility.

Line 3-16, Consultant Fees-Nursing

Fees paid to nursing personnel, not on the facility payroll, for providing advisory and educational services to the facility.

Line 3-17, Consultant Fees-Pharmacy

Fees paid to a registered pharmacist, not on the facility payroll, for

## **INSTRUCTIONS FOR FILING LONG-TERM CARE FACILITY COST REPORT**

providing advisory and educational services to the facility.

**Line 3-18, Consultant Fees-Social Worker**

Fees paid to a social worker, not on the facility payroll, for providing advisory and educational services to the facility.

**Line 3-19, Consultant Fees - Therapists**

Fees paid to licensed therapists, not on the facility payroll, for providing advisory and educational services to the facility.

**Line 3-20, Food**

Cost of food products used to provide meals and snacks to residents, including enteral feeding. Hospital-based facilities and state-owned facilities must allocate Food based on the number of meals served. Complete Schedule 17 for offset of revenue from sale of meals.

**Line 3-21, Supplies - Care Related**

The cost of supplies, including incontinence supplies (gowns, underpads and diapers - reusable and disposable), used by the care related staff for rendering care related services to the residents of the facility. Certain personal hygiene items such as shampoo and soap provided to all residents must be included on this line.

**Line 3-22, Allocated Costs-Hospital Based and State Facilities (net of capital costs)**

Care Related costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 4 and Schedule 14.

**Line 3-23, Total Care Related Costs**

Line 3-23 is the sum of Line 3-01 through Line 3-22.

**Line 4 Administrative and Operating Costs**

Administration, dietary, housekeeping, laundry, maintenance, and medical records salaries and expenses must be included in this section of the cost report. Lines 4-10 through 4-15 are for employee benefits for administration and operating salary classifications. Lines 4-16 through 4-46 capture other administrative and operating costs for the entire facility operation. For example, travel and training expenses incurred by all facility departments are reported on Line 4. (See exception explained on the instructions for Form 6, Line 2-15.)

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**Line 4-01, Salaries - Administrator**

Gross salary of licensed administrators excluding owners. Hospital-based facilities and state-owned facilities must attach a schedule of the administrator's salary before allocation, the allocation method, and the amount allocated to the nursing facility, ICF-IID or PRTF.

**Line 4-02, Salaries - Assistant Administrator**

Gross salary of licensed assistant administrators excluding owners.

**Line 4-03, Salaries - Dietary**

Gross salaries of kitchen personnel including dietary supervisor, cooks, helpers and dishwashers.

**Line 4-04, Salaries - Housekeeping**

Gross salaries of housekeeping personnel including housekeeping supervisors, maids and janitors.

**Line 4-05, Salaries - Laundry**

Gross salaries of laundry personnel.

**Line 4-06, Salaries - Maintenance**

Gross salaries of personnel involved in operating and maintaining the physical plant, including maintenance personnel or plant engineer.

**Line 4-07, Salaries - Medical Records**

Gross salaries of medical records personnel.

**Line 4-08, Salaries - Other Administrative**

Gross salaries of other administrative personnel including bookkeeper, receptionist, administrative assistants and other office and clerical personnel.

**Line 4-09, Salaries - Owner or Owner/Administrator**

Gross salaries of all owners of the facility that are paid through the facility.

**The allocation of owners' salaries between facilities should be calculated following these guidelines:**

The paid salary must be reduced to the allowable limit for the year or portion, thereof, if payment exceeded the Medicaid limit. The allowable salary must then be allocated to the various facilities based on hours spent at each facility to total hours worked on all facilities. Total hours used in the calculation must be no more than sixty (60) and no less than forty (40). When the various facilities differ

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in classification, the limit applicable to each facility classification should be used and allocated.

### Example Data:

1997 Salary Paid to Owner was \$350,000.

1997 Salary Limits: Small Nursing Facility - \$61,824

Large Nursing Facility - \$81,410

ICF-IID - \$40,533

### Example 1:

Nursing Facility A, Small	60 Beds	30 hours worked per week
Nursing Facility B, Small	60 Beds	<u>35 hours worked per week</u>
Total	120 Beds	65 hours

Limit for Nursing Facility A:

Hours:  $30/65 \times 60 = 28$

$\$61,824 \times 28/60 = \$28,851$

Limit for Nursing Facility B:

Hours:  $35/65 \times 60 = 32$

$\$61,824 \times 32/60 = \underline{\$32,973}$

Total: \$61,824

### Example 2:

Nursing Facility A, Small	60 Beds	10 hours worked per week
Nursing Facility B, Large	90 Beds	20 hours worked per week
ICF-IID Facility	75 Beds	15 hours worked per week
Non-Related Work	<u>N/A</u>	<u>15 hours worked per week</u>
Totals	225 Beds	60 hours

Total Facility hours worked was 45.

Limit for Nursing Facility A, Small:  $\$61,824 \times 10/45 = \$13,739$

Limit for Nursing Facility B, Large:  $\$81,410 \times 20/45 = \$36,182$

Limit for ICF-MR:  $\$40,533 \times 15/45 = \$13,511$

### Example 3:

Nursing Facility A, Small    60 Beds, 30 Beds Medicaid Certified  
40 Hours Worked

Limit for Nursing Facility A:  $\$61,824 \times 30/60 \text{ beds} = \$30,912$

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- Line 4-10, FICA - Administration and Operating  
Cost of employer's portion of Social Security Tax and Medicare for administration and operating employees.
- Line 4-11, Group Insurance - Administration and Operating  
Cost of employer's contribution to employee health, life, accident and disability insurance for administration and operating employees.
- Line 4-12, Pensions-Administration and Operating  
Cost of employer's contribution to employee pensions for administration and operating employees.
- Line 4-13, Unemployment Taxes-Administration and Operating  
Cost of employer's contribution to State and Federal unemployment taxes for administration and operating employees.
- Line 4-14, Uniform Allowance-Administration and Operating  
Employer's cost of uniform allowance and/or uniforms for administration and operating employees.
- Line 4-15, Workmen's Comp-Administration and Operating  
Cost of workmen's compensation insurance for administration and operating employees.
- Line 4-16, Contract - Dietary  
Cost of dietary services and personnel hired through contract who are not facility employees.
- Line 4-17, Contract-Housekeeping  
Cost of housekeeping services and personnel hired through contract who are not facility employees.
- Line 4-18, Contract - Laundry  
Cost of laundry services and personnel hired through contract who are not facility employees.
- Line 4-19, Contract - Maintenance  
Cost of maintenance services and personnel hired through contract who are not facility employees.
- Line 4-20, Consultant Fees - Dietician  
Fees paid to consulting registered dietitians.

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Line 4-21, Consultant Fees - Medical Records

Fees paid to consulting medical records Accredited Records Technicians or Medical Records Administrators.

Line 4-22, Accounting Fees

Fees incurred for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services, excluding personal tax planning and personal tax return preparation.

Line 4-23, Amortization Expense - Non-Capital

Costs incurred for legal and other expenses when organizing a corporation must be amortized over a period of sixty months. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

Line 4-24, Auto Lease

Cost of lease for vehicles used for patient care. A mileage log must be maintained. If a leased vehicle is used for both patient care purposes and personal purposes, cost must be allocated based on the mileage log. Form 9, Section I must be completed for leased vehicles.

Line 4-25, Bank Service Charges

Fees paid to banks for service charges on business bank accounts, including resident trust fund accounts. Penalties and insufficient funds charges are non-allowable. Fees for personal bank accounts are also non-allowable.

Line 4-26, Board of Directors Fees

Fees paid to members of the facility board of **directors** for attending directors' meetings (Note: The Board must have at least **two** members). The name, title, address, percentage of ownership and amount of compensation must be reported on Form 16.

Line 4-27, Dietary Supplies

Costs of consumable items such as soap, detergent, napkins, paper cups, straws, etc. used in the dietary department.

Line 4-28, Depreciation

Capital expenditures on or after January 1, 2013 of \$5,000 or more and

## INSTRUCTIONS FOR FILING LONG-TERM CARE FACILITY COST REPORT

less than the new bed value for the calendar year of purchase should be depreciated over 3 to 5 years and expensed on this line. **Depreciation expense of assets depreciated on this line will not be allowable beyond five (5) years from the date the assets were placed in service.** To determine if the capital expenditures reach or exceed the new bed value, the capitalized assets which cost \$5,000 or more, other than vehicles, should be added together. If the sum of capital expenditures for the calendar year is less than the new bed value, then all of the assets should be depreciated over 3 to 5 years and expensed on this line. All facility vehicles depreciation must be expensed on this line, regardless of the purchase date. The facility must maintain a mileage log for each vehicle. If a vehicle is used for purposes other than patient care purposes, the facility must allocate the portion used for non-patient care purposes to non-allowable costs based on the mileage log. The mileage records for owned vehicles must be reported on Form 7, Section IV. Depreciation included on this line must be excluded from Line 5-02. Facilities which capitalize assets costing less than \$5,000 and which exceed the bed value for that year should depreciate those assets for 3 to 5 years on Line 5-02. Administrative and operating depreciation expense must be reported in Section I, Column 5 of Form 7.

### Line 4-29, Dues

Dues for professional, technical, or business-related organizations and dues for civic organizations. The portion of dues associated with lobbying activities is unallowable and must be reclassified to Line 6-12.

### Line 4-30, Educational Seminars and Training

The cost of registration for attending educational seminars and training by employees of the facility and costs incurred in the provision of in-house training for facility staff. The cost of any travel incurred to attend an educational seminar must be included on Line 4-45, Travel.

### Line 4-31, Housekeeping Supplies

Cost of consumable housekeeping items including waxes, cleaners, soap, brooms and lavatory supplies.

### Line 4-32, Insurance-Professional Liability and Other

Includes the cost of insuring the facility against injury and malpractice claims and the cost of vehicle insurance. The cost of property insurance, other than vehicles, must be reported on Line 5-04.

### Line 4-33, Interest Expense - Non-Capital and Vehicles

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Interest paid on short-term borrowing for facility operations and on vehicle loans must be reported on Line 4-33. Column 1 of Line 4-33 must agree with the total column of Form 10, Line 10.

Line 4-34, Laundry Supplies

Cost of consumable goods used in the laundry including soap, detergent, starch and bleach.

Line 4-35, Legal Fees

Fees paid to attorneys in accordance with other provisions of the State Plan.

Line 4-36, Linen and Laundry Alternatives

Cost of sheets, blankets, pillows, etc.

Line 4-37, Miscellaneous

Costs incurred in providing facility services that cannot be assigned to any other line item on Form 6. Examples of miscellaneous expense are small equipment purchases, all employees' physicals and shots, nominal gifts to all employees, such as a turkey or ham at Christmas, allowable advertising, flowers purchased for facility common areas, allowable litigation deductibles and settlements, and costs to treat employee injuries not covered by worker's compensation insurance. Routine lab and x-ray costs incurred by psychiatric residential treatment facilities must be reported on this line. The physician fee for a physical exam after PRTF admission must be reported on this line. Expenses incurred by ICF-IID's for dental diagnostic and treatment services must be reported on this line. This line should also include excess revenue offsets that cannot be made to the line on Form 6 related to the revenue without creating a credit balance for that line. Line 4-37 may have a credit balance in Column 5. The expenses included on this line must be reported on Schedule 5. Expenditures for \$500 or less may be reported on one line of Schedule 5.

Line 4-38, Management Fees and Home Office Costs

The cost of purchased management services or home office costs incurred that are allocable to the provider. Costs included that are for related management/home office costs must also be reported on Form 8 and Form 17. **No management fees or home office costs are allowed to be reclassified to other lines on the cost report.**

Line 4-39, Non-Emergency Medical Transportation

The cost of purchased non-emergency medical transportation services including, but not limited to, payments to employees for use of personal

## **INSTRUCTIONS FOR FILING LONG-TERM CARE FACILITY COST REPORT**

vehicle, ambulance companies and other transportation companies for transporting residents of the facility.

**Line 4-40, Office Supplies and Subscriptions**

Cost of consumable goods used in the facility such as pencils, paper, and computer supplies. Cost of forms and stationery including, but not limited to, nursing and medical forms, accounting and census forms, charge tickets, facility letterhead and billing forms. Cost of subscribing to newspapers, magazines and periodicals.

**Line 4-41, Postage**

Cost of postage, including stamps, metered postage, freight charges and courier services.

**Line 4-42, Repairs and Maintenance**

Supplies and services, including electricians, plumbers, extended service agreements, etc., used to repair and maintain the facility building, furniture and equipment. This includes computer software maintenance and gas and oil for facility vehicles.

**Line 4-43, Taxes & Licenses**

The cost of taxes and licenses that are not included on any other line on Form 6. This includes tags for vehicles, the Medicaid bed tax and licenses for facility staff (including nurse aide re-certifications) and buildings.

**Line 4-44, Telephone and Communications**

Cost of telephone services, WATS lines and FAX services.

**Line 4-45, Travel**

Cost of travel (airfare, lodging, meals, etc.) by the Administrator and other authorized personnel to attend professional and continuing educational seminars and meetings or to conduct facility business.

In-town meals are not allowable. The in-town area includes the surrounding metropolitan area for a facility located in a metropolitan area. For example, meals and lodging expenses in Jackson for a facility in Brandon are not allowable. Commuting expenses and travel allowances are not allowable. Relocating and moving expenses are not allowable.

The expenses of a company airplane and its pilot are allowable to the extent that the prudent buyer concept is met. The flight log, a list of employees on each flight, and a calculation of cost per flight hour must be submitted with the cost report in order for the allow-ability of the costs to

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be considered. Costs to be included in the calculation, but not necessarily reported on this line, include, but are not limited to, fuel, depreciation, interest, maintenance, hangar fees and pilot costs. In addition, a comparison of these costs to commercial airfare and/or travel by vehicle must be submitted.

**Line 4-46, Utilities**

Cost of water, sewer, gas, electricity, cable TV and garbage collection services.

**Line 4-47, Allocated Costs-Hospital Based and State Facilities (net of capital costs)**

Administrative and Operating costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08. Column 1 should be zero. Facilities with costs for this line must complete Schedule 6 and Schedule 15.

**Line 4-48, Total Administrative and Operating Costs**

Line 4-48 is the sum of Line 4-01 through Line 4-47.

**Line 5 Property and Equipment**

Property costs, excluding vehicles and those capitalized assets which total less than a new bed value in any year, must be included in Lines 5-01 through 5-08.

**Line 5-01, Amortization Expense-Capital**

Legal and other costs incurred when financing the facility must be amortized over the life of the mortgage. Amortization of goodwill is not an allowable cost. Amortization of costs attributable to the negotiation or settlement of the sale or purchase of any capital asset on or after July 18, 1984, whether by acquisition or merger, for which any payment has previously been made are non-allowable costs. If allowable cost is reported on this line, an amortization schedule must be submitted with the cost report.

**Line 5-02, Depreciation**

Depreciation on the facility's buildings, furniture, equipment, leasehold improvements and land improvements. The depreciation expense incurred on capital expenditures which exceed the new bed value for the year must be reported on this line. These assets will be used to recalculate the age of the facility. To determine if the capital expenditures reach or exceed the new bed value, the capitalized assets which cost \$5,000 or more, other than vehicles, should be added together. The

## **INSTRUCTIONS FOR FILING LONG-TERM CARE FACILITY COST REPORT**

depreciation expense incurred on vehicles must be reported on or reclassified to Line 4-28. All assets except for vehicles capitalized prior to January 1, 1992 are considered as part of the facility value calculated at the start of the fair rental system and any current expense for these assets must be reported on Line 5-02. Property and equipment depreciation expense reported in Section I, Column 6 of Form 7.

**Line 5-03, Interest Expense - Capital**

Interest paid or accrued on notes, mortgages and other loans, the proceeds of which were used to purchase the facility's land, buildings and/or furniture and equipment, excluding vehicles. Column 1 of Line 5- 03 must agree with the total column of Form 10, Line 9.

**Line 5-04, Property Insurance**

Cost of fire and casualty insurance on facility buildings and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate Property Insurance based on the number of square feet.

**Line 5-05, Property Taxes**

Taxes levied on the facility's land, buildings, furniture and equipment, excluding vehicles. Hospital-based facilities and state-owned facilities must allocate Property Taxes based on the number of square feet.

**Line 5-06, Rent - Building**

Cost of leasing the facility's real property. Form 9, Section II must be completed. (For clarification related to leases from related parties, all costs incurred by the related property owner, with the exception of property insurance and property taxes, should be reported on this line in lieu of rental payments.)

**Line 5-07, Rent - Furniture and Equipment**

Cost of leasing the facility's furniture and equipment, excluding vehicles. (For clarification related to leases from related parties, all costs incurred by the related property owner, with the exception of property insurance and property taxes, should be reported on this line in lieu of rental payments.)

**Line 5-08, Allocated Costs-Hospital Based and State Facilities (from Medicare W/S B, Part II)**

Property costs that have been allocated through the step-down process from a hospital or state institution must be reclassified to this line from Line 6-08 less any amounts applicable to Lines 4-28, 5-04 and 5-05. Column 1 should be zero. Facilities with costs for this line must complete

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Schedule 7, and Schedule 16.

Line 5-09, Total Property and Equipment

Line 5-09 is the sum of Line 5-01 through Line 5-08. These totals are automatically calculated.

**Line 6 Non-Allowable Costs**

Costs which are not related to patient care or are considered non-allowable costs in accordance with ATTACHMENT 4.19-D of the Medicaid State Plan must be included on Line 6-01 through 6-15.

Line 6-01, Advertising

Costs of advertising to the general public which seeks to increase patient utilization of the nursing facility.

Line 6-02, Bad Debts

Accounts receivable written off as uncollectible.

Line 6-03, Barber and Beauty Expense

Costs directly related to the provision of barber and beauty services to residents. The costs of barber and beauty services provided for which the residents are not charged are considered allowable costs, such as routine shampoos and haircuts. The allowable barber and beauty costs must be included on Line 3-13, Barber & Beauty Expense - Allowable.

Line 6-04, Contributions

Amounts donated to charitable or other organizations and any political contributions.

Line 6-05, Feeding Assistant Training

All costs incurred in training feeding assistants in order to meet 42 CFR, Section 483.35 (4) (2) provisions. Due to the federal stipulation that these expenses qualify only for the Medicaid administrative match, these expenses cannot be allowed on the cost report. This includes both the Medicaid and non-Medicaid portion of the expenses. Costs that are not eligible or are not submitted to the Division of Medicaid for direct reimbursement must also be included on this line.

Line 6-06, Income Taxes - State and Federal

Taxes on net income levied or expected to be levied by the Federal or State government.

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**Line 6-07, Insurance – Officers**

Cost of insurance on officers and key employees of the facility when not provided to all employees or is otherwise allowed by the State Plan.

**Line 6-08, Non-Medicaid Long-Term Care Costs**

Costs allocated to portions of a facility that are not licensed as the reporting nursing facility, ICF-IID or PRTF or are not certified to participate in Title XIX. For all hospital-based facilities using a combined general ledger, this line must include all general ledger expenses not reported on any other line on Form 6.

**Line 6-09 and 6-10, Nurse Aide Testing and Training**

All costs incurred in having nurse aides tested or trained in order to meet OBRA 1987 provisions that may have been or will be submitted to the Division of Medicaid for direct reimbursement. This includes both the Medicaid and non-Medicaid portion of the expenses. Example - A nursing facility incurs \$1,000 in allowable expenses for nurse aide training. A bill is submitted to the Division of Medicaid for direct reimbursement. Based on the facility's percentage of Medicaid utilization, the facility was eligible for 80% reimbursement. A payment was made to the facility in the amount of \$800 ( $\$1,000 \times 80\%$ ) for the Medicaid portion of the nurse aide training expense. The \$1,000 should be included in non-allowable costs and the \$800 reimbursement should be included on Form 5, Line 12. Costs incurred by facilities that are not submitted to the Division of Medicaid for direct reimbursement by the deadline for submission must also be included on this line.

**Line 6-11, Other Non-Allowable Costs**

Other costs that are considered non-allowable in accordance with other provisions of the State Plan (products sold to residents, amortization of goodwill, depreciation expense on assets with a basis in excess of the Medicaid basis, lab and radiology for residents, recruiting other than advertising, relocating and moving expenses, etc.). Costs included on this line must be reported on Schedule 8.

**Line 6-12 Penalties & Sanctions**

Penalties and sanctions assessed by the Centers for Medicare and Medicaid Services, Division of Medicaid, the Internal Revenue Service or the State Tax Commission, insufficient funds charges, late fees, etc.

**Line 6-13, Pharmacy**

Cost of drugs not allowable on Line 1-14.

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Line 6-14, Television

Cost of television sets used in the residents' rooms or for providing cable TV to the residents' rooms for which a fee is charged to the residents.

Line 6-15, Vending Machines

Cost of items sold to employees, residents and the general public including candy bars and soft drinks.

Line 6-16, Total Non-Allowable Costs

Line 6-16 is the sum of Line 6-01 through Line 6-15.

Line 7 Total Non-VDC (Ventilator Dependency Care) Costs

Line 7 is the sum of the total costs of Lines 1-19, 2-17, 3-23, 4-48, 5-09 and 6-16.

Line 7-1 VDC (Ventilator Dependency Care) Costs

If applicable, enter the totals from Form 19, Line VDC-19.

Line 7-2 Total Costs

Line 7-2 is the sum of Line 7 and Line 7-1. Line 7-2, Column 1 must agree with the total expenses in the general ledger and Form 5, Line 5, Column 1. For hospital-based facilities using a combined general ledger, Line 7-2, Column 1 must tie to Schedule A, Column 3 of the hospital cost report.

Line 8 Total Patient Days

Enter the number of total patient days from Form 3, Line 5, Column A.

Computation of Allowable Cost Per Day

Enter the total allowable cost for each line from column 5 of the appropriate cost center on Form 6 in Column A. Column B is the allowable cost per day which is computed by dividing the amount in Column A by Line 8.

Line 9, Direct Care Costs

Column A must agree with Line 1-19, Column 5.

Line 10, Therapy Costs

Column A must agree with Line 2-17, Column 5

Line 11, Care Related Costs

Column A must agree with Line 3-23, Column 5.

Line 12, Administrative and Operating Costs

Column A must agree with Line 4-48, Column 5.

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### Line 13, Property Costs

Column A must agree with Line 5-09, Column 5.

### Line 14, Total Costs

Column A is the sum of Line 9 through Line 13 and must agree with Line 7, Column 5. Column B is the sum of Line 9 through Line 13.

Facilities with less than 80% occupancy for the cost reporting period must also complete Form 14.

## FORM 7 SCHEDULE OF FIXED ASSETS AND DEPRECIATION

Use this form to report the totals from the Medicaid basis depreciation schedule for this facility. A second Form 7 is available to report the property information and additions of capitalized assets owned by a Related Party lessor.

Facilities which submit a depreciation schedule not solely for the Medicaid-certified long-term care facility must prepare a summary of totals which ties to Form 7. The depreciation schedule must be set up so that direct, indirect and shared assets may be easily identified. For example, for a hospital-based nursing facility, the schedule must group hospital-only assets and nursing facility-only assets separately from each other and from shared assets. Schedules must list assets by purchase date within asset groups and departments and must be subtotaled by year of acquisition.

### Section I - Schedule of Fixed Assets

Complete the Schedule of Fixed Assets and Depreciation for each category of asset. A copy of the facility's depreciation schedule must be submitted with the cost report. The depreciation schedule must balance with the totals on Form 7.

Historical Cost - Enter the actual cost of the assets. This amount must agree with the general ledger.

Medicaid Basis - Enter the historical cost of assets, limited to the cost incurred by the first owner of record on or after July 18, 1984 in accordance with the Deficit Reduction Act of 1984 plus the cost of any additions since that date.

Ending Accumulated Depreciation, Book Basis - The total accumulated depreciation per the general ledger.

Current Period Administrative and Operating Depreciation Expense - The depreciation expense for the cost report period for assets that may be depreciated three (3) to five (5) years as an administrative and operating expense in accordance with the State Plan. For facilities which share assets with

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another distinct part, depreciation expense must be allocated based on square footage of the entities. The expense should be reported on Form 6, Line 4-28.

Current Period Property and Equipment Depreciation Expense - The depreciation expense for the cost report period for assets that are reimbursed under the fair rental system. For facilities which share assets with another distinct part, depreciation expense must be allocated based on square footage of the entities. The expense should be reported on Form 6, Line 5-02.

### Section II - Reconciliation of Cost Report Period Activity

The reconciliation of cost report period activity must reflect the assets purchased and the assets retired during the cost report period. Assets must be separated by those which are being depreciated over a 3-to-5-year period as an administrative and operating asset and those which exceed the new bed value and must be considered a renovation or major improvement.

- Line 1 - Medicaid Basis, Beginning of Cost Report Period. This line must agree with the ending Medicaid basis of capital assets on the prior period cost report on Form 7, Section II, Line 4, as adjusted by desk or field review.
- Line 2 - Additions During Cost Report Period. This line must reflect the cost of capital assets purchased during the cost report period, as determined in Section V.
- Line 3 - Deletions During Cost Report Period. This line must reflect the historical cost, limited to the amount allowed for Medicaid, of assets that were retired during the cost report period.

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Line 4 - Transfer of assets from the category of Administrative and Operating to the Property and Equipment asset category after 3 to 5 years. The total column should be zero.

Line 5 - Medicaid Basis, End of Cost Report Period. This is the sum of Lines 1 and 2, less the amount on Line 3, plus or minus the amount on Line 4. This must agree with Section I, Medicaid Basis Total.

**Section III - Assets Not Related to Patient Care**

Any assets included on Form 7 that are not related to patient care must be identified in this section. State in this section names and types of entities with which the long-term care facility shares the depreciation schedule, if applicable.

**Section IV - Vehicles**

Complete this section for all vehicles that are included in Section I.

**Section V - Current Period Asset Additions**

Complete Section V by listing all asset additions during the cost report period and entering the requested information into each column. Each asset addition must be listed on a separate line. Vehicles should be included at the bottom of the list.

All facilities which do not file cost reports on a calendar year basis must submit a schedule of fixed asset additions for each calendar year using Form 7, page 2. The schedule is required after the conclusion of each calendar year. This schedule, if submitted, will be used in computing the fixed asset additions for the gross rental per diem calculation.

Column 1     Group Asset Number  
Enter the identifier for the asset from the facility's depreciation schedule, if identifying codes are used.

Column 2     Asset Description  
Enter the asset description of each addition for the period which matches the description on the depreciation schedule. Additional copies of Form 7, page 2 of 2 may be submitted as needed.

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- Column 3     Date of Purchase  
Enter the date each asset was purchased or placed in service which matches the date entered on the depreciation schedule.
- Column 4     Asset Cost  
Enter the cost of each asset addition for the period.
- Column 5     Assets Not Used by the Medicaid Certified Portion of Long-Term Care Facility  
Enter the cost of all asset additions placed in service solely for use by the non-Medicaid Certified Portion of the facility. These assets will not be considered in the fair rental computation. Facilities within which all beds are long-term-care and certified for Medicaid will not use this column.
- Column 6     Assets Used Solely for the Medicaid Certified Portion of Long-Term Care Facility  
Enter in this column, the cost of all asset additions used solely for the Medicaid-certified long-term care facility. Facilities within which all beds are long-term care and certified for Medicaid will enter the cost of all asset additions in this column.
- Column 7     Shared Assets to be Allocated  
Enter in this column, the cost of each asset addition which is shared between the Medicaid-certified long-term care facility and a related entity (ex. hospital or personal care home).
- Column 8     Allocation Percentage  
The allocation percentage for shared assets must be the proportion of the number of Medicaid-certified long-term care facility beds to total beds represented on the depreciation schedule. This allocation percentage will be used to allocate the cost of shared assets to the certified long-term care facility. This column applies only to facilities with shared assets.
- Column 9     Basis Allocated to Medicaid Certified Portion of Long-Term Care Facility  
Column 7 multiplied by Column 8.
- Column 10    Total Asset Additions for Medicaid Long-Term Care Facility  
The sum of Columns 6 and 9. The total of Column 10 must agree with Form 7, Section II, Line 2.

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**FORM 8      FACILITY TRANSACTIONS WITH RELATED ORGANIZATIONS**

Section I.

All providers must complete this section. If yes, complete Sections II. and III.

Section II.

Identify those costs that contain expenditures for services or supplies furnished to the facility by related organizations which have common ownership, control or interlocking directors. Such expenses are allowable at the cost to the related party to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of those costs incurred by a prudent, cost-conscious buyer. Expenses for transactions with related organizations should not exceed expenses for like items in arms' length transactions with other non-related organizations. Indicate the form number and line number to designate the location of the expense. Provide the name of the related organization, the amount of current year transactions, the cost to the related organization, and the amount of the transactions in excess of cost. Provide the supporting calculation of the amount determined as the "cost to the related organization" along with any necessary documentation needed to verify the amount calculated and claimed.

The amount of transactions in excess of cost must be transferred to the appropriate line on Form 6. For example, if a facility purchased services or supplies from a related organization for \$500.00 and the cost of those services or supplies to the related organization was \$300.00, the excess over cost, or \$200.00, must be transferred to Form 6 to offset the proper expense.

An exception to the general rule applicable to related organizations is provided in the Mississippi Medicaid State Plan. If the exception has been granted by the Division of Medicaid, please note "exception" on the applicable row in the Column titled "Amount in Excess of Cost\*". Please submit a copy of the exception approval letter with the cost report.

If additional lines are needed, please submit a supplemental page using a copy of Form 8.

Section III.

List the name of each owner in the facility and their relationship with organizations described in Section II. If additional lines are needed, please submit a supplemental page using a copy of Form 8.

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**FORM 9      RENTAL OF VEHICLES AND PROPERTY**

**Section I – Auto Lease Payments Included on Form 6, Line 4-24**

List any leases pertaining to vehicles in Section I. Identify the lessor, the leased item, the terms of the lease including the amount of the monthly payment, and the percentage of personal usage. Enter the lease expense applicable to the current reporting period in Column 1. In Column 3, enter the amount applicable to the Medicaid-certified portion of the facility. Multiply Column 3 by the percentage of personal use and enter in Column 4. Use the total of Column 4 to enter an adjustment on the adjustments report for personal usage. Subtract Column 4 from Column 3 and enter in Column 5. Column totals must tie to Form 6, Line 4-24.

**Section II - Rental Payments Included on Form 6, Line 5-06**

List any leases pertaining to buildings. Identify the lessor, the leased item, the terms of the lease including the amount of the monthly payment, a description of the purchase option, if any, and the amount of rent applicable to the current reporting period. The total amount of the Current Period Expense column must agree with Form 6, Line 5-06, Column 5.

**FORM 10      ANALYSIS OF INTEREST-BEARING DEBT AND RELATED INTEREST  
EXPENSE**

All interest-bearing debt must be reported on Form 10. Each note must be listed under the columns for Note 1 - Note 11. Totals must be entered in the Totals column. If the facility had more than eleven (11) notes payable during the reporting period, please complete an additional Form 10.

Line 1      Report the lender's name. If the lender is a related party or if the note is inter-company, please enter "RP" in the cell with the lender's name.

Line 2      Balance at the beginning of the cost reporting period. The total of notes payable (current and long-term) reported on Form 11, Column 1.

Line 3      Balance at the end of the reporting period. The total of notes payable (current and long-term) reported on Form 11, column 2.

Line 4      The current portion of interest-bearing debt. The portion due within one year must be reported in this column for all interest-bearing debt. The total of this line must agree with the amount on Form 11, line 24, column

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- Line 5        The non-current portion of long-term notes payable must be reported in this column. The total must agree with Form 11, line 31, column 2.
- Line 6        Describe the terms of the debt.
- Line 7        Describe the purpose of the loan. For example, mortgage of building, purchase of equipment, working capital, etc.
- Line 8        List the interest rate.
- Line 9        Report the allowable capital interest expense for the cost reporting period. Line 9, totals column must agree with Form 6, Line 5-03, Column 1, unless interest expense is reported on Form 6, Line 5-08.
- Line 10       Report the allowable non-capital or vehicle interest expense for the cost reporting period. Line 10, totals column must agree with Form 6, Line 4-33, Column 1, unless interest expense is reported on Form 6, Line 4-47.
- Line 11       Report the non-allowable interest expense for the cost reporting period.

**FORM 11    BALANCE SHEET**

The balance sheet as of the beginning of the reporting period must be reported in Column 1 and must agree with the end of the reporting period balance sheet submitted on the previous cost report. Facilities filing an initial cost report should report in Column 1 the balance sheet as of the first day of the cost reporting period. Changes to the beginning balance sheet and prior period adjustments must be explained on Form 12. The balance sheet as of the end of the reporting period must be reported in Column 2. Hospital-based facilities and state-owned facilities may report the balance sheet of the nursing facility combined with the hospital or other non-Medicaid certified portions of the facility if a separate balance sheet is not available.

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- Line 1      Cash on Hand & in Banks includes all funds actually on hand or in bank accounts subject to immediate withdrawal. Facilities with accounts other than operating accounts must attach a schedule that includes the type of account, whether or not the account is interest bearing and whether or not the account is restricted.
- Resident fund accounts held on behalf of the residents are not considered facility accounts and should not be included on the balance sheet.
- Line 2      Accounts Receivable represents monies due the facility for services rendered to patients as of the balance sheet date. The dollar amount recorded on the schedule should represent gross accounts.
- Line 3      Allowance for Uncollectible Accounts should include the estimated loss for accounts receivable that will not be collected.
- Line 4      Notes Receivable includes the current portion of notes other than those due from officers, owners, and/or related organizations.
- Line 5      Due from Officers, Owners, and/or Related Organizations represent amounts owed the facility by officers, owners, and/or related parties as of the balance sheet date.
- Line 6      Other Receivables include all current receivables which are not appropriately included on another line such as amounts due from a previous owner.
- Line 7      Inter-Company Receivables represent amounts owed the facility by a home office or other nursing facility in a multi-facility operation.
- Line 8      Inventory includes those goods awaiting sale or use and excludes those long-term assets subject to depreciation.  
Inventories are normally conservatively valued at the lower of "cost or market". List the method of inventory valuation in the space provided. Inventories may include dietary supplies, housekeeping and linen, general stores and others in accordance with the practice in each individual facility.

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- Line 9        Prepaid Expenses represent the portion of the expenditures which will be carried forward into the next accounting period as a proper expense in another year. Examples of prepaid expenses include membership dues, insurance premiums, rent, service contracts, etc.
- Line 10       Investments are normally permanent or long-term securities with value, but which are normally not available for immediate withdrawal. Investments include stock and bonds, certificates of deposit, etc. It will be assumed that all investments are for a period greater than six (6) months unless documentation is submitted with the cost report that indicates otherwise.
- Line 11       Other Current Assets include all current assets which are not appropriately included on any other line of the balance sheet. These assets should be listed on the lines available on Form 11.
- Line 12       Total Current Assets is the sum of Line 1 through Line 11.
- Line 13       Property, Plant and Equipment must agree with the total of all assets recorded on Form 7, Section 1, Column 2. Property not related to patient care should not be offset on Form 11.
- Line 14       Less Accumulated Depreciation represents a reduction of the property, plant, and equipment reported on Line 13. The amount reported in the ending column must agree with the total accumulated depreciation reported on Form 7, Section I, Column 4.
- Line 15       Total Fixed Assets is the difference between Line 13 and Line 14.
- Line 16       Notes Receivable-Non-current includes the non-current portion of notes other than those due from officers, owners, and related organizations.
- Line 17       Due from Officers, Owners, and/or Related Organizations under Other Assets includes the non-current portion of amounts owed from officers, owners, and related organizations.
- Line 18       Goodwill represents the amount paid for the nursing facility in excess of the recognized value of the other assets acquired.

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- Line 19      Deposits include amounts used to secure accounts with utility companies, for workers compensation insurance or with lessors, for example. Deposits must be reported on Schedule 10.
- Line 20      Other Non-current Assets represent those non-current assets which are not appropriately reported on any other line (ex. organization costs). These assets must be listed in the spaces available on Form 11.
- Line 21      Total Other Assets reports the sum of amounts recorded on Lines 16 through 20.
- Line 22      Total Assets represents the sum of amounts recorded on Lines 12, 15, and 21 of the balance sheet.
- Line 23      Accounts Payable represent liabilities of daily transactions normally kept on open account and are limited to amounts owed to specific creditors for goods and services purchased. Exclude accounts payable owed to related parties.
- Line 24      Notes Payable and Current Portion of Long-Term Debt includes obligations that are scheduled to mature within one year after the balance sheet date and the current portion of long-term debt.
- Line 25      Accrued Salaries represent the salaries and wages earned by employees but not paid during the accounting period. To be recognized as an allowable expense, salaries accrued at the end of the accounting year must be paid within seventy-five (75) days of the year end.
- Line 26      Accrued Payroll Taxes include non-deposited federal and state income and FICA taxes withheld. It also includes union dues and insurance withheld and the employers' liability for FICA and unemployment taxes.
- Line 27      Accrued Income Taxes include any liability the facility has for federal and state income taxes.
- Line 28      Inter-company Payables represent amounts owed by the facility to a home office or other nursing facility in a multi-facility operation.
- Line 29      Other Current Liabilities represent any current obligations not included elsewhere on Form 11, Lines 23-28. These liabilities should be listed on

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the lines provided.

- Line 30 Total Current Liabilities reports the sum of amounts reported on Lines 23 through 29.
- Line 31 Notes Payable - Long-Term include obligations that are scheduled to mature after one year from the balance sheet date.
- Line 32 Notes Payable to Officers, Owners and/or Related Organizations represent liabilities to officers, owners, and/or related organizations.
- Line 33 Total Long-Term Liabilities reports the sum of Lines 31 and 32.
- Line 34 Total Liabilities is the sum of current liabilities (Line 30) and long-term liabilities (Line 33).
- Lines 35-41 Capital includes lines that apply to proprietorships, partnerships, governmental facilities, limited liability companies, and corporations. Only the applicable lines should be completed.
- Line 42 Total Capital is the sum of amounts reported on Lines 35 through 41.
- Line 43 Total Liabilities and Capital is the sum of Total Liabilities (Line 34) and Total Capital (Line 42). Total Liabilities and Capital must agree with Total Assets (Line 22) of the balance sheet.

**FORM 12 CAPITAL RECONCILIATION**

Total Capital at Beginning of Period must agree with Form 11, Line 42, Column 1.

Additions to Capital - All additions to capital must be included in this section.

Line 1 Net Income for Period must agree with Form 5, Line 25, Column 1.

Line 2 Contributions to capital and the date the contribution was made must be reported on separate lines. If additional lines are needed, a schedule should be attached

Lines 3 - 4 List any other additions to capital.

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Reductions to Capital - All reductions to capital must be included in this section.

Line 1 Dividends include those dividends declared during the cost reporting period.

Line 2 Owners' Withdrawals and the date each withdrawal was made must be reported on separate lines. If additional lines are needed, a schedule should be attached.

Lines 3 - 4 List any other reductions to capital.

Ending Capital - Total Capital at End of Reporting Period must equal the amount on Form 11, Line 42, Column 2.

**FORM 13 COMPUTATION OF RETURN ON EQUITY**

Equity is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) excluding net property, plant and equipment other than vehicles and liabilities associated therewith, and those assets and liabilities which are not related to the provision of patient care. Line 1 must agree with the prior period's cost report, as adjusted by desk review or financial review by the Division of Medicaid's fiscal agent. Line 2, Column 1 must agree with Form 11, Line 42, Column 2. Adjustments should be made on this form to exclude certain items from equity as specified in the Long-term Care Reimbursement Plan. The following are examples of items not included in the computation of non-property equity:

- A. Property, plant and equipment, excluding vehicles
- B. Debt related to property, plant and equipment, excluding vehicles
- C. Liabilities related to property, plant and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance
- D. Notes and loans receivable from owners or related organizations

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- E. Goodwill
- F. Unpaid capital surplus (undistributed dividends)
- G. Workmen's Compensation Self Insurance Fund
- H. Unrealized capital appreciation surplus
- I. Cash surrender value of life insurance policies
- J. Prepaid premiums on life insurance policies
- K. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period.
- L. Inter-company accounts
- M. Funded depreciation
- N. Cash investments that are long-term (more than six months)
- O. Deferred tax liability attributed to non-allowable tax expense
- P. Any other assets not directly related to or necessary for the provision of patient care
- Q. Net capitalized loan/financing costs
- R. Resident fund accounts held on behalf of the resident which were included on Form 11

Providers that are members of chain operations must also include a share of the equity of the home office, allocated based on CMS Publication 15-1 guidelines. The home office equity must be calculated using Form 18, Computation of Return on Equity for Home Office.

Facilities using a working trial balance combined for the reporting facility and another entity(s) for this cost report must complete Lines 1 - 3, Column 1 using the combined balance sheet. An adjustment must be made on Line 4 to reduce the average equity to include only the portion allocable to the Medicaid certified portion of the reporting facility. This allocation must be made based on the ratio of allowable costs from Form 6,

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Line 7, Column 5 to total costs of the entities reported on Form 6, Line 7, Column 1.

- Line 4      Line 3, Column 4 divided by 2. For facilities using a combined balance sheet, enter the facility percentage in column 3 (Form 6, Line 7, Column 5 divided by Form 6, Line 7, Column 1, rounded to two decimals (example: 96.41%)). Divide Form 13, Line 3, Column 4 by 2; multiply the product by the facility percentage in Line 4, Column 3. If Line 3, Column 4 is negative, report \$0.
- Line 5      Total Allowable Costs from Form 6, Line 7, Column 5 divided by the number of months in the reporting period multiplied by 2.
- Line 6      Enter the lesser of Line 4 or Line 5.
- Line 8      Line 6 multiplied by Line 7, but not less than zero.
- Line 9      The greater of Form 3, Line 5, Column A or 80% occupancy.
- Line 10     Enter the number of months in the reporting period. Round to two (2) decimal places.
- Line 12     Line 9 divided by Line 10 multiplied by Line 11. The annualized patient days must be based on an occupancy percentage of at least 80%. Please note that the annualized patient days actually used for ROE and property rate-setting may not agree with the cost report for facilities with occupancy less than 80% during the cost report period or have experienced a change in the number of beds. For rate-setting, days must be based on the number of beds certified for Medicaid at the end of the rate period and the occupancy rate of the facility during the cost report period, as reported on Form 3 unless it is less than 80%. (For example, Form 3, Line 8 multiplied by Form 3, Line 10 multiplied by 365 days or 366 if a leap year.) or if less than 80% occupancy during the cost report period (Form 3, Line 8 multiplied by 80% multiplied by 365 days or 366 if a leap year.)
- Line 13     Line 8 divided by Line 12.

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### **FORM 14    COMPUTATION OF PER DIEM COST FOR FACILITIES WITH LESS THAN 80% OCCUPANCY**

This form is required only if the total occupancy rate computed on Form 3, Line 10 is below 80%. The occupancy minimum is applied to care related and administrative and operating fixed costs. If the occupancy level is below 80%, the reported lower level of occupancy will apply to variable costs.

The allowable cost from Form 6, Column 5 must be entered in Column 1 on Form 14 for Care Related Costs and Administrative and Operating Costs. These costs must be extended into either Column 2 for variable costs or Column 3 for fixed costs. Facilities using allocated cost lines on Form 6 must analyze those expenses to distinguish between variable and fixed costs in order to determine the correct column. Page 3 of Form 14 must be completed to compute the allowable cost per day for each cost center.

### **FORM 15    OWNERS', OFFICERS' AND DIRECTORS' COMPENSATION**

A separate Form 15 must be completed for each owner or officer listed on Form 16, whether or not any compensation is claimed on the cost report. A separate Form 15 must also be completed for each director listed on Form 16 for whom compensation, excluding board of director's fees, is claimed on the cost report. Compensation is considered claimed on the cost report whether paid directly by the facility or indirectly by the facility through cost allocations. Additional copies of Form 15 should be made as needed. Compensation other than salary must be specified under other compensation. Examples of such compensation are given on Form 15. If there is not enough space for required entries under Section VI, please submit supplemental pages.

The limits and calculation guidelines for reasonableness of owner's salaries apply to salaries reported on Form 15 for owners, officers, and directors, and their immediate relatives.

### **FORM 16    DISCLOSURE OF OWNERSHIP**

Each provider is required to complete the applicable section of this form for their type of ownership. List all having five percent (5%) or more ownership, all officers and all members of the Board during the cost report period. List the required information for each level of the ownership structure. The amount of compensation includes the amounts directly from the facility and amounts allocated from the home office and related management company. This amount must tie to Form 15, section 1, unless the only compensation is director fees and Form 15 is not required.

### **FORM 17    HOME OFFICE OR RELATED MANAGEMENT COMPANY COST**

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**REPORT EXPENSE ALLOCATION SUMMARY**

Each provider that reports expense on Form 6, Line 4-38 or Form 6, Line 4-47 as a result of home office costs or management fees paid to a related management company must complete Form 17. Complete a separate Form 17 for each related management company and home office with cost stepped down directly or indirectly to the facility. Form(s) 17 will be accepted for the most recent Medicare cost report period, even if the cost report period does not match the Medicaid report of the facility. The form is to be used to report the allocation of indirectly related expenses as well as directly related expenses from the home office or related management company. Refer to cost report instructions for Forms 5 and 6 for assistance in determining revenue offsets and allow-ability of costs.

A copy of the working trial balance must be submitted to support each Form 17. A copy of an amortization schedule and depreciation schedule must be submitted to support costs reported on Lines 2-10 and 2-13.

**Section 1 - Revenue**

This section must include the total revenue of the home office or related management company. Schedule 11 must be completed for revenue included on Line 1-08.

Column 1	This column must agree with the general ledger of the home office or the management company.
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Column 2	This column is used to show revenue offsets against expenses.
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**Section 2 - Expenditures**

Lines 2-01 through 2-29 must be used to report the expenses for the described accounts. All expense accounts that are not listed in Section 2 must be reported on Line 2-27, Other Expense. The sum of Columns 2 and 4 must equal Column 1 in Section 2.

For related management companies and home offices with more than one Medicaid participating facility, Columns 1, 2 and 4 of Sections 1 and 2 must agree.

Column 1	This column must agree with the general ledger of the home office or the management company.
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Column 2	This column must include adjustments made to remove
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expenses not related to patient care, revenues offset against expenses, and expenses directly related to **all** facilities.

Column 3	Expenses that are directly related to the management of the facility for which the cost report is being filed must be reported on Column 3.
Column 4	Column 1 less Column 2 must be reported in Column 4. These are the expenses to be allocated to all facilities managed by the home office or the management company.
Column 5	Column 4 multiplied by the allocation percentage related to the facility for which the cost report is being filed must be reported in Column 5.

Cost reports with expenses on Form 17, line number 2-27, Other Expense must complete Schedule 12.

### **Allocation of Owners' Salaries between facilities should be calculated following these guidelines:**

The paid salary must be reduced to the allowable limit for the year or portion, thereof, if payment exceeded the Medicaid limit. The allowable salary must then be allocated to the various facilities based on hours spent at each facility to total hours worked on all facilities. Total hours used in the calculation must be no more than sixty (60) and no less than forty (40). The allocation of hours to each facility may be calculated using the expense allocation factor. When the various facilities differ in classification, the limit applicable to each facility classification should be used and allocated.

#### **Example Data:**

1997 Salary Paid to Owner was \$350,000.

1997 Salary Limits:	Small Nursing Facility - \$61,824
	Large Nursing Facility - \$81,410
	ICF-IID - \$40,533

#### **Example 1:**

Nursing Facility A, Small	60 Beds	30 hours worked per week
Nursing Facility B, Small	60 Beds	35 hours worked per week
Total	120 Beds	65 hours

Limit for Nursing Facility A:  
Hours:  $30/65 \times 60 = 28$

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$\$61,824 \times 28/60 = \$28,851$   
Limit for Nursing Facility B:  
Hours:  $35/65 \times 60 = 32$   
 $\$61,824 \times 32/60 = \underline{\$32,973}$   
Total:  $\$61,824$

### Example 2:

Nursing Facility A, Small	60 Beds	10 hours worked per week
Nursing Facility B, Large	90 Beds	20 hours worked per week
ICF-IID Facility	75 Beds	15 hours worked per week
Non-Related Work	N/A	15 hours worked per week
Totals	225 Beds	60 hours

Total Facility hours worked was 45.

Limit for Nursing Facility A, Small:  $\$61,824 \times 10/45 = \$13,739$

Limit for Nursing Facility B, Large:  $\$81,410 \times 20/45 = \$36,182$

Limit for ICF-IID:  $\$40,533 \times 15/45 = \$13,511$

### Example 3:

Nursing Facility A, Small 60 Beds, 30 Beds Medicaid Certified 40 Hours Worked

Limit for Nursing Facility A:  $\$61,824 \times 30/60 \text{ beds} = \$30,912$

### Section 3 - Calculation of Allowable Expenditures

Line 3-01, Expenditures Directly Related to the Facility

This line must include the total expenses directly related to this facility from Form 17, Line 2-30, Column 3.

Line 3-02, Expenditures Allocated to this Facility

This line must include the total amount of this facility's allocated portion of the indirectly related expenses from Form 17, Line 2-30, Column 5.

Line 3-03, Total Allowable Expenditures

The sum of lines 3-01 and 3-02. Enter on Form 6, Line 4-38.

### Section 4 - Description of Allocation Methods

This section should be used to describe the methodology used to allocate home office or related management company expenditures to this facility. If more than one method was used, define to which expense accounts each method was

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applied. The allocation method used must comply with Medicare guidelines as stated in the CMS Publication 15-1 beginning with Section 2150.3D2. The allocation calculation(s) must be included in Section 4 or on an attachment.

### FORM 18 COMPUTATION OF RETURN ON EQUITY FOR HOME OFFICE

For the definition of a “Home Office” please reference 42 CFR Section 421.404. Follow instructions for Form 13. However, **do not** exclude home office net property, plant and equipment and liabilities associated therewith.

### FORM 19 VENTILATOR DEPENDENT CARE EXPENSES

This form is required only for nursing facilities that have been approved by DOM for ventilator dependent care services. These providers will be paid a pre-established per diem rate by the Division in addition to the standard per diem. Form 19, Ventilator Dependent Care (VDC), expenses will be reported by the provider in addition to the usual nursing facility costs reported on Form 6. Form 19 will be used to track the additional costs related to the VDC services.

The VDC costs must be identified, segregated and reported in the facility’s working trial balance to support the costs on Form 19. All schedules (including a copy of an amortization schedule and depreciation schedule) and work-papers supporting Form 19 must be identified and submitted to support costs reported on the appropriate Form lines. The following cost report line titles and descriptions are primarily the same as those delineated in the above “FORM 6 SCHEDULE OF EXPENSES” section, but are VDC specific, with an additional line added for reporting of respiratory therapists’ salaries.

**Must isolate all VDC-related expenses in a standalone trial balance.**

#### Line VDC Ventilator Dependent Care Expenses

Costs of all specific VDC personnel and services (including direct care, therapy, care- related, administrative & operating, and equipment rental), above the facility’s usual nursing care costs included on its Form 6, Sections 1 – 6, must be included on Form 19, Line VDC-01 through VDC-18. Lines VDC-04 through VDC-09 are for employee benefits for the ventilator dependent care unit employees not reported on any other line of the cost report. Please refer to the above Form 6 instructions and explanations for the same and similar line titles and descriptions to report the appropriate expenses on the lines below for VDC services. Note that for costs to be reported on any of the Form 19 lines below, they must be incurred for the necessary and required operations in the treatment of VDC patients.

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Line VDC-01, Salaries-LPNs-VDC  
Line VDC-02, Salaries-RNs-VDC  
Line VDC-03, Salaries-Respiratory Therapists-VDC  
Line VDC-04, Salaries-FICA-VDC  
Line VDC-05, Group Insurance-VDC  
Line VDC-06, Pension-VDC  
Line VDC-07, Unemployment Taxes-VDC  
Line VDC-08, Uniform Allowance-VDC  
Line VDC-09, Workmen's Comp-VDC  
Line VDC-10, Contract Nursing-VDC  
Line VDC-11, Contract Therapy-VDC  
Line VDC-12, Consultant Fees-VDC  
Line VDC-13, Specialized Medical Supplies-VDC  
Line VDC-14, Educational Seminars & Training-VDC  
Line VDC-15, Miscellaneous-VDC  
Line VDC-16, Taxes & Licenses-VDC  
Line VDC-17, Travel-VDC  
Line VDC-18, Rent-Furniture & Equipment-VDC  
Line VDC-19, Total Ventilator Dependent Care Expenses  
Line VDC-20, Patient Days-VDC  
Line VDC-21, Total Ventilator Dependent Care Costs per Day

### **SCHEDULES 1 THROUGH 17**

Descriptions must be detailed enough for determination of allow-ability and correct classification of costs.

#### **SCHEDULE 1**

This schedule should be used to describe the revenues included on Form 5, Line 15. The amounts from the general ledger that pertain to the Medicaid Certified Portion of the Long-term Care Facility for which the cost report is being filed must be reported in Column 2. Any adjustments made as a result of a revenue offset or cost finding must be reported in Column 3. Please list the Form 6 or Medicare cost report line numbers where adjustments were entered in Column 4.

#### **SCHEDULE 2**

Direct care line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 2, Columns 2 through 5 must agree with Form 6, Line 1-21. Any non-Medicare cost report reclassifications/adjustments that are not listed on

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Schedules 13 or 14 should be listed on the reclassification or adjustment schedules.

### **SCHEDULE 3**

Therapy line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 3, Columns 2 through 5 must agree with Form 6, Line 2-16. Any non-Medicare cost report reclassifications/adjustments that are not listed on Schedules 13 or 15 should be listed on the reclassification or adjustment schedules.

### **SCHEDULE 4**

Care related line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 4, Columns 2 through 5 must agree with Form 6, Line 3-22. Any non-Medicare cost report reclassifications/adjustments that are not listed on Schedules 13 or 14 should be listed on the reclassification or adjustment schedules.

### **SCHEDULE 5**

This schedule must detail miscellaneous expenses. Expenditures for \$500 and under may be combined and entered on one line of the schedule with the description, "Amounts \$500 and under". The totals shown for each column must agree with Form 6, Line 4-37. "Miscellaneous", "other", "various", and "etc." are not acceptable descriptions. Submit a list explaining abbreviations and acronyms used on the schedule.

### **SCHEDULE 6**

Administrative and operating line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 6, Columns 2 through 5 must agree with Form 6, Line 4-47. Variable/Fixed allocations are defaulted to the allocations shown on Form 14 (if applicable) however can be updated in Columns 6 and 7, if appropriate.

### **SCHEDULE 7**

Property and equipment line-item costs stepped down from the Medicare cost report must be listed. The total amounts on Schedule 7, Columns 2 through 5 must agree with Form 6, Line 5-08.

### **SCHEDULE 8**

Describe each of the expenses reported on Form 6, Line 6-11. The total amounts must agree with Form 6, Line 6-11.

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**SCHEDULE 9**

Enter the prior and current reporting period cost from Form 6, column 5 in columns 1 and 4, respectively. Enter prior and current reporting period total patient days from Form 3, Line 5, column A in columns 2 and 5, respectively. Calculate the cost per diem for column 3 by dividing column 1 by column 2. Divide column 4 by column 5 to calculate the cost per diem for column 6. The percent variance for column 7 is calculated by first subtracting column 3 from column 6. Then, the difference should be divided by column 3. For variances exceeding both ten percent and \$1,000, enter an explanation for the increase. Please note that small and large nursing facilities are not required to complete the explanation for Line 2-15, Therapy Costs, Other.

Line 1-14, Drugs - Allowable

Line 1-15, Medical Supplies

Line 1-17, Other Supplies

Line 2-15, Therapy Costs, Other

Line 3-21, Supplies – Care Related

Line 4-08, Salaries – Other Administrative

Line 4-15, Workmen's Compensation Line 4-22, Accounting Fees

Line 4-29, Dues

Line 4-30, Educational Seminars & Training

Line 4-32, Insurance – Professional Liability and Other

Line 4-35, Legal Fees

Line 4-36, Linen & Laundry Alternatives

Line 4-38, Management Fees & Home Office Costs

Line 4-40, Office Supplies & Subscriptions

Line 4-42, Repairs & Maintenance

Line 4-43, Taxes & Licenses

Line 4-45, Travel

Line 5-04, Property Insurance

Line 5-05, Property Taxes

**SCHEDULE 10**

Deposits reported on Schedule 10 must agree with Form 11, Line 19. Deposits at the beginning of the cost report period must be reported in Column 1 and ending balances must be reported in Column 2.

**SCHEDULE 11**

This schedule must be used to describe Other Income for the home office. Amounts must agree with Form 17, Line 1-08. The amounts from the general ledger must be

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reported in Column 1 and any adjustments made must be reported in Column 2.

### **SCHEDULE 12**

This schedule must detail other home office expenses. Only amounts over \$500 are required to be detailed. Amounts \$500 and under should be combined and entered on one line of the schedule with the description, "Amounts \$500 and under". The total amounts must agree with Form 17, Line 2-27. "Miscellaneous", "other", "various", and "etc." are not acceptable descriptions. Submit a list explaining abbreviations and acronyms used on the schedule.

### **Schedule 13**

This schedule is to apportion any allocated employee benefit costs appearing on the Medicare cost report W/S B, Part I column 4, nursing facility (or SNF) line as applicable. Total direct salaries, from Form 6, are matched to the allocation statistic for Employee Benefits, column 4 of W/S B-1, for proper apportionment to the various sections of Form 6. This is a supplement to Schedules 2, 3, and 14.

### **Schedule 13A**

This schedule must be completed if any capital costs are allocated to the Employee Benefits line of W/S B, Part I. The resulting net expense will be used to complete schedules 13 and 14.

### **Schedule 14**

This schedule is to apportion any allocated expenses to determine the appropriate amounts of Line 1-18 and Line 3-22 of Form 6 for Direct Care and Care Related Expenses, respectively. The amounts to be included in column 2 are for direct care and care related supplies and contract personnel only. Equipment purchases, equipment rentals, pens, pencils, paper, copier supplies, parts for repairs, etc. should not be reported in this column as they are administrative costs and not direct care or care related expenses. This allowed amount is reported on Schedules 2 and 4 to adjust allocated expenses per W/S B Part I to the correct amounts. Supplement to Schedules 2 and 4.

### **Schedule 15**

This schedule is to remove any capital costs allocated to the areas reported as Administrative and Operating on Line 4-47. This is a supplement to Schedule 6. Variable/Fixed allocations are defaulted to the allocations shown on Form 14 (if applicable) however can be updated in Columns 6 and 7, if appropriate

### **Schedule 16**

This schedule separates capital costs allocated to the NF/SNF in W/S B, Part I of the Medicare cost report. W/S B, Part II is utilized to identify all capital costs allocated to

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the nursing facility. Amounts applicable to Line 4-28, Line 5-04 should be removed from the total allocated and reported on their respective lines to determine the amount applicable to Line 5-08. Also remove the amounts included on Lines 5-02, 5-05, and 5-07 if allocated through W/S B, Pt I as part of capital related costs. Supplement to Schedule 7.

**Schedule 17**

This schedule is to allocate raw food costs net of applicable “meals sold” revenue to be reported on line 3-20. The raw food costs include the portion applicable to resident meals and employee meals served in the cafeteria.