INTERMEDIATE CARE FACILITY/MENTAL RETARDATION
(Small 6-Bed Facilities)

COST REPORT INSTRUCTIONS

GENERAL INSTRUCTIONS

Intermediate Care/Mental Retardation Facilities are required to submit a Cost Report to the Cost Settlement and Audit Contractor within 90 days of the close of the facility's fiscal year end. Failure to file a report when due, unless an extension of time is requested at least 15 days before the cost report is due and granted by the Nevada Division of Health Care Financing & Policy may result in reduction of payments, termination of payments, or termination of participation as considered appropriate by the Nevada Division of Health Care Financing & Policy.

This report can either be manually prepared or if the capability is available, a computerized Excel version on CD or via e-mail is available upon request from the Cost Settlement and Audit Contractor.

Providers are required to maintain adequate financial records and statistical data for proper determination of costs allowable under the program. The report is to be based on financial and statistical records maintained by the facility. Cost information must be current, accurate, and in sufficient detail to support the claimed expenses. This includes all ledgers, sub-ledgers, books, records, and original evidence of cost (invoices, purchase requisitions, purchase orders, vouchers, payroll records, receipts, insurance and/or real estate and property tax statements, lease/purchase agreements, basis for apportioning cost, etc.) which pertain to the determination of allowable cost. These financial and statistical records must be such as to allow proper verification by audit. Costs that are inadequately documented or not clearly identifiable will not be allowed.

Allowable expenses arrived at on Worksheet 2 are governed by Medicare rules for hospital reimbursement as stated in Provider Reimbursement Manual (HIM 15), as modified by the state plan requirements mandated by CMS for ICF/MR, and as modified by the State Plan for Nevada and the Division of Health Care Financing and Policy Medicaid Services Manual Chapter 1600.

The period covered by the cost report is to be a 12 month period conforming to the facility's fiscal year for financial statements unless an exception is requested at least 15 days prior to the cost report due date and is granted by the Division of Health Care Financing & Policy.

Amounts entered on the cost report are to be rounded to the nearest whole dollar, except for cost per patient day, or as specified. Cost per patient day is to be rounded to the nearest cent.

All cost report schedules must be completed. A detail year to date general ledger, if applicable, is required to be filed with the cost report. If the general ledger does not contain sufficient detail to list vendor payment information, then the related accounts payable or cash disbursements journals must also accompany the cost report and the general ledger. If additional schedules are necessary to effect proper cost determination according to the regulations, these schedules must be attached. If all applicable reports are not filed or are not complete, the cost report will be returned to the provider and/or it will not be accepted by the Cost Settlement and Audit Contractor until all information required to be filed with the cost report has been submitted in acceptable form.

For amounts reported in column 1, Worksheet 2 if the provider combines or separates amounts reported in the general ledger accounts in order to report these amounts according to our cost report classifications, a reconciliation between the general ledger amounts and the amounts reported on the cost report lines must be clearly noted. This can be done either by showing the account number for each line on Worksheet 2, or by showing on the trial balance submitted with the cost report, the schedule and line numbers where the general ledger amount was placed on the cost report. Alternately, a separate reconciliation schedule may be submitted.

All amounts in the cost report should be reported in a proper debit or (credit) manner.

EXAMPLE: All liabilities and revenues would be represented by brackets ( ), or a (-).

CLASSIFICATIONS AND SPECIFIC DOCUMENTATION REQUIREMENTS

Vehicle Expense (Worksheet 2, Line 17) may include the following for vehicles used to transport residents:

- Depreciation expense for purchased vehicles
- Vehicle lease or rental expense
- Vehicle repair and maintenance expenses
- Fuel expense
- Interest paid on purchased vehicles financed through a third party
- Vehicle insurance expense
- Vehicle license and registration fees

Rent/Lease Expense (Worksheet 2, Line 24) may include the following:

- Depreciation expense for purchased resident homes
- Mortgage interest paid for purchased resident homes financed through a third party
- Rental or lease payments for resident homes that are not purchased

Depreciation Expense (Worksheet 2, Line 25) may include the following:

- Depreciation expense on capital assets (depreciation on real property and vehicles is excluded)

Other Property Costs (Worksheet 2, Line 26) may include the following:

- Property insurance expense
- Real and personal property tax expense
- Minor equipment expense (under $500 and/or less than 2 years useful life)
- Interest paid on capital assets financed through a third party (interest on real property and vehicles is excluded)

Travel Expenses for corporate and regional office personnel should be claimed at Worksheet 2, Line 5 and included in Management Fee/H.O./Regional Office Costs. Expense reports must be complete and must clearly indicate the name of the person performing the travel, the purposes of the travel and the dates of the travel and all receipts pertaining to expenses claimed must be attached to the expense report. The exception would apply if the corporate office has a written travel policy designating a specific amount or limitation allowing for corporate reimbursement without a signed or written receipt. In such cases, the written

corporate travel policy must be made available to the Cost Settlement and Audit Contractor upon request.

Consultant Costs: all consultant invoices for Medical Doctors, Psychologists, Psychiatrists, Physical Therapists, Speech Therapists or Occupational Therapists must clearly indicate the type of service performed, the date and length of time spent with each resident and must be clearly marked that the service is being performed in compliance with a resident's Individual Program Plan (IPP) in order to be considered reimbursable on the cost report for Medicaid purposes. Invoices not clearly so marked will be disallowed on the cost report as a service performed by a personal attending physician which should be billed to Medicaid separately by the Medicaid Provider using his or her Medicaid Provider Number.

Telephone expenses should be included in "Other Administrative Costs" on Worksheet 2, Line 6. Utilities expenses should be included in "Other - Housekeeping" on Worksheet 2, Line 12.

"Other Care Costs" (Worksheet 2, Line 19) should include Program Supplies, Program Activities, Pharmacy (non-legend drugs only) and Medical Supplies, Personal Care Items and Contract Nursing Services.

Pharmacy Consultants should be claimed in "Consultants" on Worksheet 2, Line 16.

Employee Benefits such as Safety Awards, meals for employees or staff meetings, employee gifts, flowers or promotion items are non-reimbursable items and should be reversed out of claimed costs on Worksheet 2, Column 2, "Provider Adjustments".

The time period allowed to submit "Missing documentation" to the Cost Settlement and Audit Contractor is 15 days from the date of receipt of the Missing Documentation List from the Cost Settlement and Audit Contractor. Documentation submitted after this time period will not be accepted by the Cost Settlement and Audit Contractor or included in claimed costs allowable on the cost report unless explicit, written authorization is received from the Cost Settlement and Audit Contractor due to extenuating circumstances.

Questions regarding other classification and/or documentation requirements should be directed to the Cost Settlement and Audit Contractor prior to completing the cost report.

WORKSHEET 1: GENERAL INFORMATION

Complete all information requested. Complete the certification. An original signature for the certification must appear on the copies of the cost report submitted.

The basis for cost calculation is a cost per patient day. This schedule must be completed so that the number of patient days can be determined for proper calculation of Medicaid cost.

BEDS AVAILABLE

LINE 1: List the number of certified beds at the beginning of the period.

LINE 2: List the number of days in the reporting period.

LINE 3: List the total of bed days available, determined by multiplying the number of beds times the number of days available (lines 1 multiplied by line 2).

LINE 4: Complete the number of patients, both Medicaid and other. List total in column 7.

LINE 5: Complete the number of inpatient days both Medicaid and other. List total in column 7. List total Medicaid patients for portion of year in the column relating to that portion of the year. For 12/31 fiscal year end facilities, columns 1 and 4 will have patient days entered for both columns. For 6/30 fiscal year end facilities, only column 4 will be applicable.

LINE 6: Respite (and/or other, if applicable) Complete the number of days. List total in column 7.

LINE 7: Column 7 should be completed. Total in column 7 consists of the total of lines 5 and 6.

NOTE: If using our computerized method (a CD or e-mail copy which is available upon request) the totals are automatically computed for you.

WORKSHEET 2: TRIAL BALANCE/EXPENSES

COLUMN 1: Complete column 1 for each cost center from the facility's trial balance.

COLUMN 2: Enter any adjustments for reclassifications or disallowed expenses.

COLUMN 3: Total of columns 1 and 2 for all lines (this will be automatically totaled if you are using the copy supplied by the Cost Settlement and Audit Contractor.)

COLUMN 4: Reserved for audit adjustments made by Cost Settlement and Audit Contractor.

COLUMN 5: Final total after audit adjustments (the as-filed cost report will have the same total as column 3.)

Each column must also be totaled.

LINE 17: **NOTE: Line** 17 Vehicle Expense includes the cost of ownership for the facility's van. This expense includes lease payments OR interest and depreciation expense, in addition to insurance expense, maintenance and repair costs, license and registration fees and fuel expense.

LINE 22: Line 22 of each column consists of the totals from lines 7, 13, 20, and 21.

LINE 23: Day training costs are defined as the cost of the contracts to provide day training at State specified rates.

LINES 24 - 27:

Property-related costs include property taxes, mortgage interest, rent, property insurance,

depreciation/amortization, and gains or losses on sale of depreciable assets. CMS Publication 15 will be used to further define and clarify any issues not specifically addressed herein.

DEPRECIATION/AMORTIZATION of depreciable assets used to render patient care is an allowable cost. If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost of at least $500, its cost must be capitalized and written off ratably over the estimated useful life of the asset, using the straight-line method of depreciation. If a depreciable asset has a historical cost of less than $500, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired, as minor equipment expense. The provider may establish a capitalization policy with lower minimum criteria, but may not establish a policy exceeding the above criteria. Betterments or improvements must be capitalized. Repairs and maintenance are allowed in the current period and are expensed in the housekeeping cost area.

ESTIMATED USEFUL LIFE (EUL). Unless an EUL is specifically designated for an account below, the provider must use the EUL specified in American Hospital Association guidelines. For assets acquired before 1982, the guidelines specified in the 1973 Edition of the AHA's Chart of Accounts for Hospitals or those guidelines published in the Internal Revenue Service, former Revenue Procedure 62-21, 1962-2, CB418 (Bulletin F), must be used. For assets acquired in 1982, providers must use the 1978 Edition of the Estimated Useful Lives of Depreciable Hospital Assets. For assets acquired after 1982, providers must use the EUL's from the 1983 edition of the Estimated Useful Lives of Depreciable Hospital Assets. For assets acquired on or after 3/1/93, providers must use the EUL's from the 1993 edition of the Estimated Useful Lives of Depreciable Hospital Assets. For assets acquired on or after January 1, 2000, providers must use the EUL's from the 1998 edition of the Estimated Useful Lives of Depreciable Hospital Assets. For assets acquired on or after May 1, 2004, providers must use the EUL's from the 2004 edition of the Estimated Useful Lives of Depreciable Hospital Assets. A composite life may be used for a class or group of assets.

While the straight-line depreciation method is the only acceptable method of depreciation, providers will be allowed to use the base stock or replacement method of depreciation for a quantity purchase of low cost assets. Such quantity purchase must be in excess of $1,000. This method is normally only used to capitalize minor equipment (dishes, silverware, linen, minor office equipment, etc.) necessary prior to the opening of a facility or an expansion. Under this method, the original purchase is capitalized, but not depreciated. Instead, replacements to the base stock are expensed in the period the replacement occurs.

Depreciation expense, to be acceptable, must be adequately supported by the providers accounting records, including identification of the depreciable assets in use, the assets historical cost and salvage value, date of acquisition, method of depreciation, EUL, and accumulated depreciation.

1. Historical cost: Allowable historical cost for the Medicaid program for purchases occurring on or after July 1, 1986 will be determined according to Medicare regulations as published in CMS Publication 15. Accordingly, historical cost shall not exceed the lower of (1) current reproduction cost adjusted for straight-line depreciation over the life of the asset to the time of purchase, or (2) fair market value at the time of purchase. A gain or loss upon the disposal of assets is treated in accordance with the rules stated in HCFA Publication 15.

2. Property taxes include personal and real property taxes levied for the current year by a

Nevada governmental entity. Only taxes levied on property used in patient care is allowable. Penalties and late payment fees are not allowable. Allowable taxes for the current year are based on the assessment year stated on the tax bill, not on the basis of the payment due date.

3. Interest on capital indebtedness: For interest to be allowable, it must meet the definitions of "necessary" and "proper." Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities, equipment, and capital improvements. Penalties and finance charges assessed for late payments are not an allowable cost.

4. Fire/property insurance premiums include premiums for fire/property insurance coverage necessary to prudent operation of the facility; premiums for lives of officers or key employees where provider is the beneficiary are not an allowable cost. If someone other than the facility is the beneficiary and coverage is substantially in excess of coverage for other employees, the premiums shall be considered additional compensation.

5. Rent/lease expenses are incurred for lease or rental costs of all capital assets. Guidelines established in CMS Publication 15 should be used to determine amount allowable, including but not limited to regulations regarding a virtual purchase, sale-leaseback, and rental/lease from related organizations.

6. Depreciation-building: Buildings (basic structure or shell and additions thereto) must be depreciated over a 40 year EUL.

7. Depreciation-building equipment: Building equipment (components of the building affixed to the building and not subject to transfer, such as plumbing fixtures and heating systems) may be separated from building cost and depreciated over a useful life indicated in the AHA guidelines for EUL.

8. Amortization of leasehold improvements: Leasehold improvements are betterments and additions made by provider which become the property of the owner after expiration of the lease; cost of improvements that are provider's responsibility under the terms of his lease may be depreciated over the useful life of the improvement or the remaining term of the lease, whichever is shorter.

9. Depreciation of major movable equipment are items with relatively fixed locations but capable of being moved about in the facility, of sufficient size and identity to be controlled by identification tags, with unit cost justifying ledger control. Beds, desks, dressers, office equipment, filing cabinets, dishwashers, dryers, washing machines, buffers.

10. Minor equipment expense: Items with no particular location, comparatively small in size or unit cost with an EUL of less than that which would require capitalization.

LINE 28: Total costs for each column consists of lines 22, 23, and 27.

WORKSHEET 3: RECLASSIFICATION AND ADJUSTMENTS

This form must list each adjustment or reclassification in order to conform to Medicaid cost finding. For example, property insurance cost may be included in Administrative Costs in the provider books, but it should be reclassified to Other Property Costs in order to properly classify it for Medicaid purposes.

NOTE: All allowable home office costs must be claimed as an adjustment to Line 5 - Management Fee/H.O./Regional Office Costs. Do not allocate home office costs to any other cost center.

WORKSHEET 4: PAYMENT SETTLEMENT

LINE 2: MEDICAID RATE: Column 1 and Column 2 - The appropriate rate for the facility for each portion of the audit period. **DO NOT CHANGE THE RATES LISTED.**

LINE 10, COLUMN 1 : CUSTOMARY CHARGE PPD (must be entered)

LINE 12 : LESS: AMOUNTS PAID BY MEDICAID AND OTHER RESOURCES (must be entered)

If the above lines are not completed, the cost report will be returned to Provider as incomplete.

FOR MANUAL PREPARATION:

Fill in the totals on the appropriate lines 1 through 9.

LINE 1: Nevada Medicaid Days for each period from Worksheet 1, line 5, columns 3 and 6.

LINE 2: Medicaid Rate is listed in column 1 and column 2 – The appropriate rate for the facility for each portion of the audit period. DO NOT CHANGE THE RATES LISTED.

LINE 3: Multiply line 1 by line 2, columns 1 and 2.

LINE 4: Enter the total of line 3, columns 1 and 2.

LINE 7: Enter total from Worksheet 2, line 23, column 5.

LINE 8: Enter total from Worksheet 2, line 27, column 5.

LINE 9: Add lines 4, 7, and 8.

LINE 10: Enter customary charge per patient day in box in column 1. Enter the total of customary charge per patient day times total Medicaid patient days (from line 1, column 1 plus column 2).

LINE 11: Enter the lesser of line 9 or line 10.

LINE 12: Enter amounts paid by Medicaid and other resources for services provided this cost reporting period. Please include interim settlements and/or adjustments for the cost reporting period although these should be clearly marked as such.

LINE 13: Fiscal Agent Adjustment

LINE 14: Adjusted total paid (audited) sum of lines 12 and 13.

LINE 15: Subtract line 14 from line 11.

NOTE: If line 10, Customary Charge and line 12, Amounts Paid By Medicaid and Other Resources are not completed the cost report will be returned to you for completion before being accepted by the Cost Settlement and Audit Contractor.