

# **INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES COST REPORT**

**NOTE: This cost reporting form is used for cost reimbursed ICF/IID Facilities, i.e.: Desert Regional Center, Sierra Regional Center, and Eagle Valley Children's Home.**

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

## **GENERAL INSTRUCTIONS**

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) 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.

Providers are required to maintain adequate financial records and statistical data for proper determination of costs reimbursable 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 claim for cost reimbursement. This includes all ledgers, books, records and original evidence of cost (invoices, purchase requisitions, purchase orders, vouchers, payroll records, basis for apportioning cost, etc.) which pertain to the determination of reimbursable cost. These financial and statistical records must be such as to allow proper verification by audit. Costs that are inadequately documented or not 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.

The period covered by the cost report is to be a 12-month period conforming to the facility's fiscal year for financial statements.

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

All cost report schedules must be completed. If additional schedules are necessary to effect proper cost reimbursement 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.

For amounts reported in column 1 and 2 of 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 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.

Each amount in columns 1 and 2, Worksheet 2, should be reported in a proper debit or (credit) manner.

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

**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 reimbursement is a cost per patient day. This schedule must be completed so that the number of patient days can be determined for proper reimbursement 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.
- 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 is available upon request) the totals are automatically computed.

**WORKSHEET 2: TRIAL BALANCE**

- COLUMNS 1 and 2: Complete columns 1 and 2 for each cost center from the facility's trial balance. Column 1 should contain only salaries of facility employees. Contracted therapists or consultants should be included in column 2.
- COLUMN 3: Enter any adjustments for reclassification.
- COLUMN 4: Total for columns 1 thru 3 (automatically totaled if using the copy supplied by the Cost Settlement and Audit Contractor).
- COLUMN 5: Reserved for audit adjustments.
- COLUMN 6: Final total (the as-filed cost report will have the same total as column 4). Each column must also be totaled.

**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 "Depreciation" in order to properly allocate it.

**NOTE:**        **All allowable home office cost must be claimed as an adjustment to Administration and General. Do not allocate home office costs to any other cost center.**

**WORKSHEET 4-A:    ALLOCATION BASES**

**GENERAL:**    This schedule is used to accumulate the allocation bases for use in allocating overhead to ancillary, routine and non-reimbursable cost centers on Worksheet 4-B.

**COLUMN 1:**        Enter the square footage for each cost center, lines 1 thru 9.

**COLUMN 2:**        Enter the salaries attributed to each cost center, line 1 thru 9. Amounts should agree with the amounts on Worksheet 2, column 1, lines 12 thru 20 plus or minus any adjustments/reclassification affecting salaries.

**PLEASE NOTE:**    **FOR EAGLE VALLEY CHILDRENS HOME ONLY:**

Provider allocates employee benefits costs directly to non-reimbursable respite cost center. Ancillary cost centers have no salary expense, therefore no benefits expense. No allocation of benefits expense is required.

**COLUMN 3:**        Enter the number of meals served for each cost center, lines 1 thru 9.

**COLUMN 4:**        Enter the pounds of laundry attributed to each cost center, lines 1 thru 9.

Total each column and enter the results on line 10.

Enter line 11 as follows:

From Worksheet 2 Column 6

To Worksheet 4-A, Line 11

Line 7

Column 1

Line 8

Column 2

Line 9

Column 3

Line 10

Column 4

**NOTE:**        If using the computer program, the cost for each category will automatically flow forward.

**CAUTION:**    If there is cost to be entered on line 11, columns 1 thru 4, statistics must be entered or the program will not compute. It will be necessary to plug

100 into line 10 for that category.

LINE 12: For each column, divide line 11 by line 10 and enter the results, carried to six decimal places.

LINE 13: Enter the total from Worksheet 2, line 11, column 6.

**(Note: Before line 14 can be complete, Worksheet 4-B, column 1 thru 6 must be completed.)**

LINE 14: Enter the accumulated cost from Worksheet 4-B, line 10, column 6.

LINE 15: Divide line 13 by line 14 and enter the results, carried to six decimal places.

**WORKSHEET 4-B: OVERHEAD ALLOCATION**

COLUMN 1: Enter, on lines 1 thru 9, the corresponding totals from Worksheet 2, column 6, lines 12 thru 20. Total this column and enter the result on line 10.

COLUMN 2: DEPRECIATION, HOUSEKEEPING, MAINTENANCE/REPAIR AND OTHER.

**FROM WORKSHEET 4-A:**

Multiply the unit cost multiplier, column 1, line 12 by each line of column 1 and enter the result on the corresponding line of column 2 on Worksheet 4-B.

Total the column and enter on line 10. (If done correctly, the amounts on Worksheet 4-B, line 10, will agree with the amounts on Worksheet 4-A, line 11.)

COLUMN 3: EMPLOYEE BENEFITS

**FROM WORKSHEET 4-A:**

Multiply the unit multiplier, column 2, line 12 by each line of column 2 and enter the result on the corresponding line of column 3, Worksheet 4-B. Total the column and enter on line 10.

COLUMN 4: DIETARY

**FROM WORKSHEET 4-A:**

Multiply the unit multiplier, column 3, line 12 by each line of column 3 and enter the result on the corresponding line of column 4, Worksheet 4-B. Total the column and enter on line 10.

COLUMN 5: LAUNDRY

**FROM WORKSHEET 4-A:**

Multiply the unit multiplier column 4, line 12 by each line of column 4, and enter the result on the corresponding line of column 5, Worksheet 4-B. Total the column and enter on line 10.

COLUMN 6: SUB-TOTALS

For each of lines 1 – 9, add the entries in columns 1 – 5 and enter the sub-totals on the respective lines in column 6. Total the results on line 10.

COLUMN 7: ADMINISTRATIVE & GENERAL

FROM WORKSHEET 4-A:

Multiply the unit multiplier from column 2, line 15 of Worksheet 4-A by each of the subtotals for lines 1-9 in column 6 on Worksheet 4-B. Enter the results on the respective lines in column 7 on Worksheet 4-B. Total the results on line 10.

**COLUMN 8: TOTALS**

Add the subtotals from column 6 and the A & G allocations from column 7 and enter the totals on the respective lines in column 8.

WORKSHEET 5: REIMBURSEMENT SETTLEMENT

If using our software the totals for each line will be brought forward automatically, **except:**

LINE 11: CUSTOMARY CHARGE (must be entered) and

LINE 15: LESS: AMOUNTS PAID BY MEDICAID AND OTHER RESOURCES

FOR MANUAL PREPARATION:

Fill in the totals on the appropriate lines 1 thru 7 (from WORKSHEET 4-B, COLUMN 8, and TOTAL LINE 8)

LINE 9: Fill in the total resident days (from Worksheet 1)

LINE 10: Divide line 8 by line 9 (rounded to nearest cent)

LINE 11: Enter your customary charge (what you would charge a client responsible for their own payment)

LINE 12: Enter the lesser of lines 10 or 11

LINE 13: Enter Nevada Medicaid Days (from Worksheet 1)

LINE 14: Multiply line 12 by line 13 and enter the result

LINE 15: Enter the total amount paid by Medicaid and all other resources

LINE 16: Fiscal Agent Adjustment

LINE 17: Total adjusted (audited) payments

LINE 18: Subtract line 17 from line 14 and enter the results. If this results in money owed Medicaid, enclose a check made payable to Nevada Medicaid.

NOTE: If lines 11, Customary Charge and line 15, Amounts Paid By Medicaid and Other Resources, are not completed the cost report will be returned to you for completion.