NEVADA MEDICAID
FREESTANDING
LONG-TERM CARE FACILITY

COST REPORT INSTRUCTIONS

Revised April 2010

(Use for Cost Report Periods Ending After December 31, 2009.)

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INTRODUCTION

The attached cost reporting forms and the instructions for their completion were designed to be used for cost reporting periods ending after December 31, 2007. All costs on the cost report must be filed according to the rules for this period, even though many policy changes may not have been in effect for the full cost reporting period.

These forms supersede all previously issued forms. Substitution of any previously issued form does not meet the filing requirements under the Title XIX Program.

These forms must be used by all Freestanding Long-Term Care nursing facilities. Information reported must conform to the requirements and principles set forth in these cost report instructions. Any questions not specifically covered in these instructions will be handled according to the instructions in the Provider Reimbursement Manual, published by the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), (Publication 15-1).

Facilities that claim home office costs must submit a home office cost statement (Form CMS-287) for chain operations. A chain operation consists of a group of two or more health care facilities or at least one health care facility and any other business or entity which is owned, leased, or through any other device, controlled by one organization.

Providers are required to maintain adequate financial records and statistical data for proper determination of costs. Providers must follow generally accepted accounting principles. Cost information as developed by the provider must be current, accurate, and in sufficient detail to support the claimed cost. This includes all ledgers, books, records and original evidences of costs (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, basis for apportioning costs, etc.), which pertain to the determination of reasonable cost, capable of being audited. Costs that are inadequately documented or not identifiable will not be allowed.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant change is made to the Cost Settlement and Audit Contractor.

Appropriate audits, utilizing generally accepted auditing standards, will be conducted by the Cost Settlement and Audit Contractor for the Medicaid Program to verify accuracy and reasonableness of information and cost contained in all financial and statistical reports. A provider must make available its fiscal and other records for the purpose of determining its ongoing record keeping capability.

GENERAL INSTRUCTIONS

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The Cost Settlement and Audit Contractor must **receive** cost reports that have been postmarked within 90 days after the close of the facility's fiscal year end unless the Division of Health Care Financing and Policy grants an extension of time.

Failure to file a report when due will result in a late filing penalty of $500 for the first day late, plus an additional $50 for each day thereafter until a completed cost report has been received by the Cost Settlement and Audit Contractor. Failure to file a cost report when due may also result in the reduction of payments, the termination of payments, or the termination of participation as considered appropriate by the Division of Health Care Financing and Policy.

An electronic "Windows" version CD-ROM of the cost report (Excel 2003) and the instructions (Word 2003) are available from the Cost Settlement and Audit Contractor upon request.

Cost reports along with the required documentation must be mailed "**Certified, Return Receipt Requested"** or **Overnight Courier Service.**

A completed cost report includes all pages of the cost report form and all required documentation. Failure to submit all documentation required with the cost report may result in the cost report not being accepted by the Cost Settlement and Audit Contractor and could result in additional penalties in accordance with guidelines issued by the State of Nevada.

The Nevada Medicaid Cost Report must be submitted in electronic form using the current format. Noncompliant Cost Reports will not be accepted and will be returned. Documentation (in electronic form when possible) that is required for a completed cost report includes:

- (Required) An electronic copy of the cost report on CD or DVD. Note: A floppy disk is no longer acceptable.
- (Required) Two hard copies of the certification page (p. 4) with original signatures.
- (Optional) Two hard copies of the cost report
- The working trial balance of the facility. A working trial balance is a listing of the balances of the accounts in the general ledger to which adjustments are appended in supplementary columns and used as a basic summary for financial statements.
- Depreciation schedules for the fiscal period end including schedules of additions and deletions.
- Detail General Ledger (In Excel when possible) covering the entire reporting period. If the general ledger does not list individual invoices, then the related accounts payable register or cash disbursement journal must also be included.
- Reconciliation (mapping) of the general ledger account numbers to specific lines on the cost report. This reconciliation is required for Worksheets C-1, C-2 and C-3 of the cost report.

- If the provider is subject to independent audit, a copy of the audit report should be provided.

- If the provider is certified for participation in the Medicare (Title XVIII) Program, a copy of the Medicare cost report must be filed and postmarked within the Medicare stipulated time frames.

- If the provider is claiming home office costs and home office equity, a copy of the Medicare home office cost report must be filed and postmarked within the Medicare stipulated time frames.

Facilities which are unable to comply with the regulations regarding general ledger detail or other documentation (accounts payable or cash disbursement journals) must immediately notify the Cost Settlement and Audit Contractor to arrange for pre-audit work to be done at the facility or at another location designated by the provider. In this situation, the pre-audit work will be performed at the provider's expense. These payments will not be an allowable cost in subsequent cost reports. Failure to reimburse the Cost Settlement and Audit Contractor for these costs could result in the withholding of future Medicaid payments to the facility.

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

The period covered by the cost report is to be a twelve-month period conforming to the facility's fiscal year for financial statements. Alternate arrangements must be agreed to in writing by the Division of Health Care Financing and Policy. A copy of the agreement must be included with the filed cost report.

For new facilities in their initial reporting period, the period covered by the cost report may be less or more than a full year and shall end on the ending date of the facility's fiscal year.

For facilities whose Medicaid provider agreement has been terminated, the period covered by the cost report may be less than a full year. The report will begin on the beginning date of the facility's fiscal year and may end on the termination date of the facility's provider agreement or the ending date of the facility's fiscal year.

A terminating provider must file the cost report with a postmark that is within 45 days of the date the provider agreement is terminated.

For both new and terminated providers, permission may be granted by the Division of Healthcare Financing and Policy for filing a cost report covering a period different than twelve months if it is in the interest of the Nevada Medicaid Program to do so.

Copies of journal entries alone do not represent competent evidential substantiation. Please be prepared to provide copies of the original documentation (invoices, contract agreements, etc.) which support the origination of the journal entry. Methodologies for allocation of costs are also required when applicable.

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WORKSHEET INSTRUCTIONS

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

All Worksheets must be completed. If a Worksheet is not applicable, "N/A" should be entered in column 5 of the Index of Worksheets for Submission (page 3). If additional Worksheets are necessary to effect proper cost reporting according to the regulations, or to allocate costs to non-reimbursable types of care, these Worksheets must be attached. **If all applicable reports are not filed or are not complete (except Worksheet G-1), the Cost Settlement and Audit Contractor will not accept the cost report and appropriate penalties may be assessed.**

Shaded fields are either self-calculating or are provided for Cost Settlement and Audit Contractor adjustments. Normally, data should not be entered in these fields unless totals are required in a manual submission. In the Excel spreadsheet, these fields have been protected to prevent changes from being made.

In the worksheet instructions that follow, instructions should be skipped for items that calculate automatically in the electronic version. No entries should be made in the Cost Settlement and Audit Contractor Adjustment columns. The Cost Settlement and Audit Contractor will adjust as necessary during the audit process.

Dollar amounts should be rounded to the nearest whole dollar except where per patient day, per bed value and summary rate calculations are concerned. Date information should be entered in the format mm/dd/year in all instances.

Do not add or delete lines and/or columns or modify any format in the Excel spreadsheet. Input information specified in these instructions refers to data input into the Excel spreadsheet. Some adaptations will need to be made for those who do not use the provided electronic spreadsheet.

PAGE 1: TITLE PAGE AND INSTRUCTIONS

This page provides basic instructions for using the Excel file provided by the Cost Settlement and Audit Contractor. The Provider Name, National Provider Identifier (NPI), the cost report beginning date (mm/dd/year) and the cost report ending date (mm/dd/year) are entered on *this page only* for electronic submission. This information will automatically transfer to other Worksheets as necessary. Providers submitting manual reports should enter the Provider name, National Provider Identifier (NPI) and cost report period on each page of the report. Enter the physical address of the Provider on line 2. Indicate if submission is manual or electronic. The bottom section of this page is for Cost Settlement and Audit Contractor use only.

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PAGE 2-3: CHECKLIST

- Part I provides a checklist for the provider to use as a reminder of the required documentation for a completed cost report. Complete Part I as necessary.

- Part II is the "Settlement Report" which is generated if a settlement amount is due to Nevada Medicaid as calculated on Worksheet G-1. If a balance is due Nevada Medicaid, the Department may recoup that amount from future Medicaid payments to the provider.

- Part III - The purpose of the “Index of Worksheets for Submission” is to identify each Worksheet that is being completed or is not applicable as a part of the cost report. Each Worksheet must be marked "Yes" if completed or "N/A" in Part III on page 3.

PAGE 4: WORKSHEET A -- PROVIDER INFORMATION AND CERTIFICATION

- Enter on appropriate lines: the Federal I.D. number, the licensed Administrator's name, the facility phone and fax numbers, the name of the individual or firm preparing the cost report, the contact person and contact information. Telephone and fax numbers must include the area code.

- Type of Control - Select the type of ownership or auspices under which the business is conducted.

- Certification Statement – The Provider name, National Provider Identifier (NPI), beginning period date and the ending period date are all entered as appropriate. Enter the name of the individual signing the certification, their title and the date the individual signs the statement in the appropriate spaces. The signature of the individual signing the statement must be legible. An original signature for the certification must appear on both copies of the cost report submitted.

PAGE 5: WORKSHEET B -- FISCAL STATISTICAL DATA

The basis for determining cost is a cost per patient day. This Worksheet must be completed so that the number and type of care for all patient days can be determined. Total patient days will be the basis for allocation of operating costs and capital costs in the cost reporting process.

BEDS AVAILABLE

1. Enter the number of beds available for use by patients at the beginning of the period with the number of Medicaid certified beds in column 3, the number of Non-Medicaid certified beds in column 4. Calculate the total number of beds in column 5 as the total of column 3 and column 4.

2. If any change occurred in the number of beds during the period, enter the effective date (mm/dd/year) of the change in column 1 where indicated. Enter the number of beds increased or (decreased) by this change in columns 3 and 4 as appropriate and calculate the total in column 5.

3. Calculate the number of beds at the end of the period for each column as the sum of line 1 and line 2 for each column.

4. Enter the number of days in the period pertaining to each column. Column 1 includes the number of days from the beginning to the end of the reporting period. Column 2 includes the number of days from the effective date of any increase (decrease) in the number of beds to the end of the reporting period. The number in column 1 is calculated as the beginning of the cost report period to the end of the cost report period (normally 365 days). The number in column 2 is calculated as the effective date of the increase (decrease) in the number of beds to the end of the cost report period (anywhere from 1 to 365 days).

5. Calculate the total bed days available as follows:

- Add the number of beds from the beginning (line 1) times the number of days in the period from the beginning (line 4, column 1) and the number of beds increased (decreased) (line 2) times the number of days in the increase (decrease) period (line 4, column 2).

LEVELS OF CARE

All cost reports are subject to audit by the Nevada Medicaid Cost Settlement and Audit Contractor. Column 2 and column 5 are reserved for Cost Settlement and Audit Contractor audit purposes only. The provider should not enter any information into these columns.

6. Enter Nursing Facility (NF) Standard Care total patient days in column 1. Enter NF Standard Care **Medicaid** patient days in column 4. Calculate as follows:

- Column 3 for each line is the sum of columns 1 and 2 as entered.
- Column 6 for each line is the sum of columns 4 and 5 as entered.
- Column 7 is column 6 divided by column 3 for each line 6 through 10.

7. Enter Non-Pediatric Ventilator Care total patient days in column 1. Enter Non-Pediatric Ventilator Care **Medicaid** patient days in column 4. Other columns are calculated as noted in line 6 above.

8. Enter Pediatric Specialty Care total patient days in column 1. Enter Pediatric Specialty Care **Medicaid** patient days in column 4. Other columns are calculated as noted in line 6 above.

9. Enter any Other Care total patient days in column 1. Enter any Other Care **Medicaid**

patient days in column 4. Other columns are calculated as noted in line 6 above.

10. Enter the total adjusted patient days and total adjusted Nevada Medicaid days as follows:

- Totals are the sum of each column, line 6 through 9 for columns 1 through 6.
- Column 7 for line 10, as noted above, is calculated as column 6 divided by column 3.

11. Percentage occupancy is the ratio of the total inpatient days to the bed days available during the cost reporting period. The percentage occupancy is calculated as line 10, column 3 divided by line 5 column 5.

PAGES 6 - 8: WORKSHEET C-1 -- BALANCE SHEET

Even though it is no longer used to determine a return on equity, all providers must complete Worksheet C-1 for ongoing data comparisons and analysis.

COLUMN 1: Enter amounts from the ***ending balances of the general ledger accounts*** for each line as appropriate. A reconciliation of the general ledger accounts to specific lines on the cost report is required for this Worksheet.

COLUMN 2: Enter adjustments and reclassifications from ***Worksheet D-2*** for each line as appropriate.

COLUMN 3: THIS COLUMN RESERVED FOR COST SETTLEMENT AND AUDIT CONTRACTOR - DO NOT USE.

COLUMN 4: Calculate the sum of columns 1 through 3 as entered.

PAGE 9: WORKSHEET C-2 -- REVENUES

The disclosure of revenue is necessary to determine net income and any necessary cost offsets for proper recognition of allowable costs. If cost offsets are necessary, the provider is required to do this with adjustments on Worksheets D-1 and D-2.

COLUMN 1: Enter amounts from the ***ending balances of the general ledger accounts*** for each line as appropriate. ***Revenues should be entered as negatives (credits)***. A reconciliation of the general ledger accounts to specific lines on the cost report is required for this Worksheet.

COLUMN 2: Enter adjustments and reclassifications from ***Worksheet D-2*** for each line as appropriate.

COLUMN 3: THIS COLUMN RESERVED FOR COST SETTLEMENT AND AUDIT CONTRACTOR - DO NOT USE.

COLUMN 4: Calculate the sum of columns 1 through 3 as entered.

PG. 10 - 15: WORKSHEET C-3 -- TRIAL BALANCE OF EXPENSES

Expenses claimed by the provider must conform to allowable costs as specified in these instructions. Worksheet C-3 records the trial balance of expenses from the accounting books and records. It also provides for any necessary reclassifications and adjustments to conform to the regulations.

In order to be considered allowable, any cost charged to this program must meet the definitions of reasonable, necessary and proper, and must be directly attributed to the correct account and cost center. Any question of allowable cost will be resolved by reference to the sources in the introduction to these instructions. If it is not addressed, it is the facility's responsibility to seek clarification from the Division of Healthcare Financing and Policy, preferably before incurring any questionable expense.

Providers must identify any organization related by common ownership or control from which services, facilities and/or supplies are purchased; cost of such purchases may not exceed the lower of actual cost to the related organization or the price of comparable items that could be purchased elsewhere. *Identification, disclosure, and adjustments for transactions with related parties are made on Worksheet D-3 and then carried to Worksheet D-1.*

COLUMN 1: Enter amounts from the ***ending balances of the general ledger accounts*** for each line as appropriate. A reconciliation of the general ledger accounts to specific lines on the cost report is required for this Worksheet.

COLUMN 2: Enter adjustments and reclassifications from ***Worksheets D-1, D-2, & D-3*** for each line as appropriate. *All adjustments in this column must be supported by entries on Worksheets D-1, D-2, or D-3*.

COLUMN 3: THIS COLUMN RESERVED FOR COST SETTLEMENT AND AUDIT CONTRACTOR - DO NOT USE.

COLUMN 4: Calculate the sum of columns 1 through 3 as entered.

Cost Center Descriptions

The trial balance of expenses is broken down into operating, employee benefit, direct health care, non-pediatric ventilator care, pediatric specialty care, capital, non-Medicaid ancillary services, and other care and non-reimbursable cost center categories. These cost categories are explained as follows:

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Operating Costs: This cost center includes all allowable costs excluding direct health care cost, capital cost and non-Medicaid portion of direct ancillary service costs. This comprises general service costs, property-related taxes and insurance, and costs necessary for the care of patients.

Employee Benefit Costs: This cost center includes those benefits provided to employees in addition to salary or wages. Employee bonus payments should be treated as salary and reflected on the appropriate salary line for the employee's department. The allowable costs in this cost center will be allocated 100% to other cost centers based on gross wages included in each cost center.

Direct Health Care Costs: This cost center includes allowable RN, LPN, and Nursing Aide salaries, a proportionate allocation of allowable employee benefits and the direct allowable cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies (Contract Nursing). Costs other than direct patient care staffing and allocations are includable in other sections of the cost report.

Non-Pediatric Ventilator Care Costs: This cost center includes the direct costs for providing special (ventilator) care services for non-pediatric patients along with an allocation of employee benefits, operating and capital costs.

Pediatric Specialty Care Costs: This cost center includes the direct costs for providing special (pediatric) care services along with an allocation of employee benefits, operating and capital costs.

Capital Costs: This cost center includes allowable depreciation, capital related interest, rent/lease, and amortization expenses.

Non-Medicaid Ancillary Costs: This cost center includes direct and appropriately allocated costs for ancillary services that are not covered in the Medicaid basic or special care daily rates. Ancillary costs which are included in the Nursing Facility Standard Care, Non-Pediatric Ventilator Care, or Pediatric Specialty Care rates or are for non-reimbursable care services should not be included here, but should be included in those areas.

Other Care and Non-Reimbursable Costs: Includes costs that are direct costs for providing non-reimbursable care services or expenses that are non-allowable by regulation or

expenses that are not related to patient care.

The following line and account descriptions can be used to classify costs within the various cost centers. A reconciliation of the general ledger accounts to specific lines on the cost report is required for this Worksheet.

OPERATING COSTS

Salaries and Wages

1. Administrator - gross salary paid to administrator

2. Asst. Administrator - gross salary paid to assistant administrator

3. Office/Clerical - gross salaries of administrative personnel including secretary, bookkeeper and telephone operator.

4. Plant Operations - gross salaries of carpenters, electricians, engineers, firemen, heating plant employees, machinists, painters, plumbers, watchmen and other employees engaged in the operation or maintenance of the building, equipment and grounds.

5. Laundry and Linen Service - gross salaries of laundry employees and those handling linens such as a seamstress, laundrymen and ironers.

6. Housekeeping - gross salaries of housekeepers, maids, porters, floor and wall washers and other housekeeping employees.

7. Dietary - gross salaries of dieticians, chefs, cooks, dishwashers and all other employees assigned to the kitchen, dining room or cafeteria.

8. Nursing Administration - gross salaries and wages for the Director of Nursing, staff coordinators, staff trainers, staff developers, and nursing personnel who do not have hands-on responsibilities.

9. Medical Records - gross salaries and wages for medical records department personnel.

10. Social Services - gross salaries for the social service director and all employees assigned to the social services department.

11. Activities - gross salaries for recreation/activities director and all other employees assigned to the recreation/activities department.

12. Central Supply/Ward Clerk - gross salaries and wages for ward clerks, medical supply clerks and other nursing support personnel who do not have on-hands responsibilities.

13. Nurse Aide Training & Instructor - nurse aide training costs are an allowable expense. The salaries of the aides and instructors during classroom training should be reported

here. Other costs of training are reported on line 51.

14. Patient Transportation – gross salaries and wages for patient van drivers.

15. Other - any other gross salaries and wages for operations not identified in any other cost center (identify in space provided).

16. Total Operating Salaries – enter the sum of lines 1 through 15 for columns 1 through 4.

Other Operating Expenses

17. Office Supplies, Printing & Postage - bookkeeping materials, pencils, ink, etc. Printed forms, stationery, etc. Cost of operating a copy or postage machine including leases and maintenance agreements. Non-capital software costs.

18. Telephone/Communications - This includes charges for telephone/telegraph services. Internet Service fees should be included here. Capital equipment depreciation or lease cost should be included in the capital cost center. Telephone services in patient rooms, when provided solely for the personal comfort of the patient, are not includable. See CMS Pub 15-1, Ch 21, Sect. 2106)

19. Management Fees/Home Office Costs - expenses for services of management from another entity and the pro-rata portion of central office expense for certain centralized services provided by the home office. Some important notes regarding home office costs follow:

- In order to meet the definition of "necessary," the provider would have been compelled to purchase services elsewhere if home/central office had not supplied them.
- In allocating home/central office costs, which cover a number of facilities, allowable management fees must be computed on basis of patient days.
- In no case may fees claimed exceed amount allowed by the Medicare program.
- Persons employed in a Nevada facility may not be included in home office charges to facility.
- Personnel employed by the home office that work in various facilities must be included in home office costs.
- Availability of home office services does not necessarily mean they are allowable. Only services needed and actually furnished to the Nevada provider may be claimed as a cost to this program.
- Related organizations submitting incorrect, unsupported or inappropriate claims for management fees will have all management fees disallowed.

- In some instances, allowable related organization costs may be recorded in various cost areas. These generally include costs incurred by the facility for services or supplies used in the facility. For example, the purchase of nursing or housekeeping supplies from a related organization would be recorded as direct expense, unless such supplies were used in the home office.

- Employee benefits paid on behalf of home office personnel must be recorded as a part of home office costs, because the benefits are not directly related to the facility.

- Direct depreciation of the facility buildings is allowable in the capital cost center, but the depreciation of home-office buildings would be recorded under home office costs.

- For further clarification of how related organization cost would be treated for reimbursement purposes, providers should consult the Provider Reimbursement Manual, HIM 15-1, chapter 10 and/or contact the Cost Settlement and Audit Contractor prior to filing a cost report in order to avoid adjustment of such costs.

20. Legal/Audit/Accounting - fees for the services of public accountants, auditors and attorneys.

- Documentation for legal expenses must include the detail showing the name or initials of the attorney or professional that worked on the case, the total hours spent for legal services on the current invoice and the detail showing what specific work was performed for the facility.
- Reimbursable costs such as reproduction fees and filing fees must also be detailed on the invoice.
- Total pages of invoices, which do not include this detail, are not considered competent, evidential matter and will not be allowable.
- Legal fees, which relate to suits against the State of Nevada, the Department of Health Care Financing and Policy or the Cost Settlement and Audit Contractor for the Medicaid Program, are non-allowable costs for reimbursement purposes.
- Suits, which are for the protection of the stockholder's interest, are non-allowable.

21. Purchased Services - fees paid to outside consultants in all of the general service areas, including:

- Medical Transcription Services
- Dietary Consultants
- Purchased Laundry Services
- Security Services
- Disposal Services
- Water Delivery Services
- Cable TV Services in public and employee areas (non-allowable in patient rooms, CMS Pub 15-1, Ch 21, Sect. 2106)

22. Maintenance/Laundry/Linen/Housekeeping Supplies - the cost of acquiring on-hand supplies and parts required by these departments to maintain the department, the equipment and/or the physical plant. Include the following in this line:

- laundry soap, bleaches, ammonia, detergents, starch, needles, thread
- replacement linen, towels, washcloths
- pads, sheets, rubber sheets, drawsheets, pillows, pillowcases, blankets, etc.
- brooms, brushes, mops
- cleaning compounds, disinfectants, germicides, insecticides, polish, soaps
- lavatory supplies (toilet paper, hand soap), paper towels, drinking cups
- lubricants, small tools, light bulbs, fuses
- any other items required to maintain the facility, grounds or departments

23. Fuel, Electric, Water & Sewage - cost of utilities and services for the physical plant. Garbage disposal should be reported on line 21.

24. Repairs and Other Maintenance Costs - cost of materials and services used in the repair of equipment and the physical plant.

25. Dietary Supplies/Raw Food - cost of supplies used in processing and preparing raw food for consumption by patients. Cost of food purchased, prepared in the regular kitchen (including special diets) and consumed by patients. Also included are dishes, glassware, silverware, paper products used in kitchen, dining room and on patients' trays, kitchen utensils, garbage cans, dish washing products, menus, bibs, aprons and all the other miscellaneous supplies and expenses of the dietary department.

26. Employee Recruitment/Direct Advertising - may include costs for want-ad advertising for new employees and a one-quarter yellow page advertisement. If advertising costs are for the purpose of increased utilization they must be adjusted out for cost report purposes. Advertising to increase utilization is non-allowable per CMS Publication 15-1 and should be reported on line 127.

27. Fingerprints/Employee Physicals - costs required to hire and retain nursing home personnel such as, TB testing and influenza vaccinations for employees, physical examinations for facility employees, employee fingerprinting and background checks as necessary.

28. Interest/Bank Charges - interest for non-property related loans should be recorded on this line. Bank overdraft charges and finance charges for late payments are not allowable. For interest to be allowable in the Administration cost area, it must be incurred for current indebtedness, not capital indebtedness, and must meet the requirements cited in CMS Publication 15-1, chapter 2, including the requirements that the loan be necessary and proper.

29. Travel, Seminars, & Administrative Training - administrative travel expenses incurred in

traveling to out-of-town conferences, conventions and institutes and local administrative personnel training. **Travel documentation must include the name of the person traveling, the person's destination, the business purpose for the travel and the amount of expense with attached receipts for that expense.** If the facility has an internal policy that does not require receipts for reimbursement if certain expenses fall under a specific limitation (for example, meals under $25 or a per diem payment only), then a copy of that policy should be provided during audit along with other travel documentation.

30. Automobile Costs - this line is used to report all non-capital expenses (e.g. gas, oil, tires, and minor repairs) related to facility vehicles **not** used for patient transportation. Depreciation and lease expense for these vehicles must be reported in the Capital Cost Center. Expenses for autos not used exclusively for facility business or patient care must have records of non-facility use adequate for prorating purposes or be disallowed. Any auto charged to the facility must be appropriate for nursing home purposes under the prudent buyer concept. Damage insurance recoveries must offset damage costs. Costs/penalties for traffic violations are non-allowable costs. Include mileage paid to employees for occasional business use of private vehicles.

31. Dues, Subscriptions, & Licenses - includes membership in professional societies, cost of trade journals, fees for institutional licenses.

32. Amortization - prorated portion of organization expense and start up costs.

33. Insurance - cost of maintaining insurance coverage necessary to the prudent operation of the facility. Include mortgage insurance and all insurance related to the property and equipment on this line. Also include liability insurance on this line. NOTE: premiums for lives of officers or key employees where the 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. Insurance costs for coverage of the vehicles(s) used to transport residents should be included in Patient Transportation Costs on line 52.

34. Personal Property Taxes - cost of personal 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.

35. Real Estate Taxes - real estate taxes levied for the current year by a Nevada governmental entity. 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.

36. Minor Equipment Expense - cost of furniture and equipment items that are under the capitalization limit and/or have a life expectancy of one year or less, i.e. items with no particular location, and/or comparatively small in size. The provider must adjust any equipment, major or minor, out when filing the cost report if it is the type of equipment not included in the rate paid to nursing facilities.

37. Storage - costs of storing supplies or records of the provider when physical plant space is not available.

38. through 39. Other - general services operating expenses not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

40. State Provider Tax – provider tax levied by the State of Nevada for the current year. Penalties and late payment fees are not allowable. Amount entered should be the total amount of tax on the provider tax returns filed for the current year which are titled "Nursing Facilities Monthly Report and Fee Assessed to Increase the Quality of Nursing Care". (Note: This tax is also commonly referred to as the "Bed Tax" or the "MDS Tax".)

41. Allocation of Employee Benefit Costs – enter the amount from Worksheet E-1, line 1 column 4 that represents that portion of employee benefit costs applicable to total operating salaries.

42. Total Other Operating Expenses – enter the sum of lines 17 through 41 for columns 1 through 4.

Other Health Care operating expense

43. Nursing Supplies - medical supplies used in direct patient care. Includes items that are furnished routinely and relatively uniformly to all patients and/or stocked in gross supply and distributed or used individually in small quantities. May include items that are considered routine for Medicaid cost reporting purposes, but ancillary by the facility. See attachment **A** for more details.

44. Durable Medical Equipment (DME) - with some exceptions, depreciation or lease expenses for DME is an allowable cost. Items such as wheelchairs, sterilizers, carts, tables, IPPB machines, room-air concentrators, ventilators, walkers, lifts, trapeze bars, seating and chairs, basins, bedpans, canes, crutches, cradles, trays, urinals, pitchers, sand bags, safety rails, heating pads, sphygmomanometers, buckets, large electronic thermometers, etc., should be reported on line 44. DME that is not allowable, e.g. clinitron beds, should be reported as an ancillary cost.

45. Oxygen Expense - this expense includes gaseous or liquid oxygen for continuing or emergency use, and oxygen supplies such as disposable masks. Purchase and/or rental of oxygen tanks, regulators and concentrators is considered a DME expense. Suppliers commonly bill for oxygen in units of "tanks". If tanks are exchanged at time of delivery, then the charge is considered an oxygen purchase and not tank rental.

46. Recreational Supplies - items used in planned group and individual recreational and social activities such as snacks in conjunction with a social activity (not part of a daily meal), games, paints, craft supplies, film rentals, reasonable entertainment, honorariums, playing cards, and party decorations.

47. Utilization Review Fees - fees for physicians' services, availability, visits and utilization review.

48. Medical Director - fees paid to an appropriately licensed physician under agreement. The medical director, pharmaceutical consultant, social work consultant, and activities consultant as a minimum, must indicate actual time in the facility and appropriate duties. These records must be available to survey and audit personnel on request. The Medicaid program will not reimburse unsupported payments/fees.

49. Pharmaceutical Consultant - fees paid to an appropriately licensed pharmacist under agreement with the facility. Includes the consulting fee charged by a licensed pharmacy which is a regularly used supplier of house and patient medications.

50. Social Service/Activities Consultant - fees paid to a licensed social worker under agreement with the facility where appropriate personnel are not on the payroll of the facility.

51. Nurse Aide Training Cost - testing and licensing fees, payment to aides or community colleges for training classes, tuition, supplies and materials, program review fees or other costs which are the result of OBRA 87 nurse aide training requirements.

52. Patient Transportation - allowable costs would include all direct costs such as gas, oil, repairs, vehicle insurance, depreciation or lease cost for patient transportation vehicles, cost of contracted carrier, etc.

53. through 54. Other – other patient care expenses not provided for above. If the total amount reported exceeds $1,000 identify in the spaces provided and/or attach a separate schedule.

55. Total Other Care Expenses – enter the sum of lines 43 through 54 for columns 1 through 4.

56. Allocation of Operating Costs to Other Cost Centers – enter as a **negative** amount, the sum of the amounts calculated on Worksheet E-2, lines 2 through 4, column 4. This amount represents that portion of the above operating costs that are allocated to other cost centers based on patient days by level of care.

57. Total Basic Care Operating Costs – enter the sum of line 16, line 42, line 55 and line 56 for columns 1 through 4.

EMPLOYEE BENEFIT COSTS

58. Payroll Taxes - the employer's share of FICA and Medicare tax expense, federal and state unemployment taxes and other taxes related directly to payroll. Penalties are not an allowable cost.

59. Worker's Compensation - worker's compensation fines or penalties are not an allowable expense. Any dividends received must be offset against expense. Worker's compensation expense rate is limited to the manual rate. Premiums paid in excess of the manual rate are non-allowable.

60. Vacation, Holiday & Sick Pay - vacation, holiday, and sick pay for facility employees are allowable on a regular accrual basis.

61. Group Insurance - the employer portion of employees' health and accident insurance or life insurance is recognized as an allowable cost in this area. Premiums for the lives of officers or key employees where the provider is the beneficiary are non-allowable.

62. through 63. Other - employee benefits expenses not provided for above. If the total amount reported exceeds $1,000 identify in the spaces provided and/or attach a separate schedule. All employee benefits (like other costs) are recognized on the accrual basis of accounting.

Allowable employee benefit costs include the costs associated with two employee parties/celebrations per year. For example, a Christmas party or summer barbecue, provided that the parties are available to all employees on an equal basis. Cash awarded to employee based on performance is considered wages and should be included in gross salary costs.

Employee benefit costs which are <u>not</u> allowable include, but are not limited to:

- employee of the month awards
- employee safety awards
- food for parties or meetings outside of the two parties mentioned above
- flowers for employees
- gifts for employees
- other costs which are considered not ordinary and necessary facility expenses
- costs deemed as not being related to patient care

64. Allocation to Other Cost Centers – enter as a **negative** amount, the total calculated on Worksheet E-1, line 7, column 4 that represents that portion of the above employee benefit costs that are allocated to cost centers based on the salaries charged within the cost center.

65. Total Employee Benefit Costs – enter the sum of lines 58 through 64 for columns 1 through 4. Because employee benefit costs are fully allocated to other cost centers on Worksheet E-1 this line should be zero for columns 3 and 4.

DIRECT HEALTH CARE COST CENTER

Direct Care Nursing Salaries and Wages

66. through 70. Salaries - these include salaries for RNs, LPNs, charge nurses, certified

nursing aides, nursing aide trainees (after completion of 16 hours of classroom instruction in an approved training program) and restorative certified nursing assistants employed by the facility. These are gross salaries and wages for personnel with hands-on care responsibilities. Bonuses for Direct Nursing Staff should be included as well.

Direct care nursing services do not include director of nursing, assistant director of nursing, MDS coordinator, In-service coordinator, patient care coordinator, staff development coordinator, ward clerk, medical records coordinator, aides in training, orientees, volunteers, and RNs, LPN or charge nurses who are classified as any of the above.

71. Total Direct Care Nursing Salaries – enter the sum of lines 66 through 70 for columns 1 through 4.

Other Direct Health Care

72. Contracted Nursing - the cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies for direct hands-on care of basic long-term care patients.

73. through 74. Other - direct health care expenses for direct hands-on care of basic long-term care patients not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

75. Allocation of Employee Benefit Costs – enter the amount from Worksheet E-1, line 2, column 4 that represents that portion of employee benefit costs applicable to total direct care nursing salaries.

76. Total Basic Direct Health Care Costs – enter the sum of lines 71 through 75 for columns 1 through 4.

NON-PEDIATRIC VENTILATOR CARE COST CENTER

Salaries and Wages

77. Nursing Salaries - gross salaries and wages for RN, LPN, NA and other personnel with hands-on care responsibilities for non-pediatric ventilator patients.

78. Respiratory Therapist Salaries - gross salaries for the respiratory or inhalation therapists.

79. Other - any other salary expenses related to the direct care of non-pediatric ventilator patients and not provided for above. If the total amount reported exceeds $1,000 identify in the spaces provided and/or attach a separate schedule.

80. Total Non-Pediatric Ventilator Care Salaries – enter the sum of lines 77 through 79 for columns 1 through 4.

Other Non-Pediatric Ventilator Care Expenses

81. Contract Nursing - the cost of acquiring RN, LPN and Nurse Aide staff from outside

staffing companies for direct hands-on care of non-pediatric ventilator patients.

82. Ventilator Rental – direct cost of ventilator equipment rental for non-pediatric ventilator care patients.

83. Oxygen and Medication – direct cost of oxygen and medications used for non-pediatric ventilator care patients.

84. through 85. Other - any other non-pediatric ventilator care expenses not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

86. Allocation of Employee Benefit Costs - enter the amount from Worksheet E-1, line 3, column 4 that represents that portion of employee benefit costs applicable to total non-pediatric ventilator care salaries.

87. Allocation of Operating Costs - enter the amount from Worksheet E-2, line 2, column 4 that represents that portion of general service (operating) costs allocated to non-pediatric ventilator care from the operating cost center based on patient days by level of care.

88. Total Non-Pediatric Ventilator Care Costs – enter the sum of lines 81 through 87 for columns 1 through 4.

PEDIATRIC SPECIALTY CARE COST CENTER

Salaries and Wages

89. Nursing Salaries - gross salaries and wages for RN, LPN, NA and other personnel with hands-on care responsibilities for pediatric specialty patients.

90. Activity Salaries - gross salaries for the pediatric specialty activity personnel.

91. through 92. Other - any other salary expenses related to the direct care of pediatric specialty patients and not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

93. Total Pediatric Specialty Care Salaries – enter the sum of lines 89 through 92 for columns 1 through 4.

Other Pediatric Specialty Care Expenses

94. Contracted Nursing - the cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies for direct hands-on care of pediatric specialty care patients.

95. Special Services - direct cost of any other special services necessary for the care of pediatric specialty patients.

96. through 97. Other - any other pediatric specialty care expenses not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

98. Allocation of Employee Benefit Costs – enter the amount from Worksheet E-1, line 4, column 4 that represents that portion of employee benefit costs applicable to total pediatric specialty care salaries.

99. Allocation of Operating Costs - enter the amount from Worksheet E-2, line 3, column 4 that represents that portion of general service (operating) costs allocated to pediatric specialty care from the operating cost center based on patient days by level of care.

100. Total Pediatric Specialty Care Costs – enter the sum of lines 93 through 99 for columns 1 through 4.

CAPITAL COST CENTER

101. Mortgage Interest Expense - the allowable portion of interest incurred by the provider on a loan that is secured by a mortgage as a lien on the assets used for patient care. For interest to be allowable, it must meet the definitions of "necessary" and "proper."

102. Other Capital Related Interest Expense - interest on other capital indebtedness such as the cost incurred for funds borrowed for equipment, and capital improvements. This line also includes the current period write-off of financing expenses. Penalties and finance charges assessed for late payments are not an allowable cost.

103. Rent/Lease Expense - Buildings & Land - cost incurred for lease or rental of the land or buildings used by the provider for patient care. Guidelines established in CMS Publication 15-1 should be used to determine the amount allowable, including but not limited to regulations regarding a virtual purchase, sale-leaseback, and rental/lease from related organizations.

104. Rent/Lease Expense - Equipment - costs incurred for lease or rental of major movable equipment used by the provider for patient care. This does not include patient transportation equipment, durable medical equipment, office equipment, or ancillary equipment, which are identified elsewhere in this cost report.

105. Depreciation/Amortization - the cost of the physical plant, improvements, and capitalized equipment used for patient care written off ratably over the estimated useful life of the asset, using the straight-line method of depreciation. To be acceptable, the providers accounting records must include identification of the depreciable assets in use, the assets historical cost and salvage value, date of acquisition, EUL, method of depreciation, and accumulated depreciation. All depreciated assets must be adequately supported.

- **Capitalization:** If an asset used for patient care has, at the time of its acquisition, an

estimated useful life of at least 2 years; and an historical unit cost of at least $500, its cost must be capitalized. If a depreciable asset has a historical unit 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 on line 36. The provider may establish a capitalization policy with lower minimum criteria, but may not establish a policy exceeding the above criteria. Betterment or improvements must be capitalized. Repairs and maintenance are allowed in the current period.

- **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 the Provider Reimbursement Manual, HIM 15, Part I, chapter 1. 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 the Provider Reimbursement Manual, HIM 15, Part I, chapter 1.

- **Date of Acquisition:** Copies of journal entries alone do not represent competent evidential substantiation. Please be prepared to provide copies of the original documentation (invoices, contract agreements, etc.) which support the origination of the journal entry.

- **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 on or after January 1, 2002, providers must use the EUL from the 1998 edition of the Estimated Useful Lives of Depreciable Hospital Assets. Use the 2004 edition for assets acquired after May 1, 2004. A composite life may be used for a class or group of assets.

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

- **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.

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

- **Depreciation-major movable equipment**: Major Movable Equipment consists of 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. Examples are beds, desks, dressers, office equipment, filing cabinets, dishwashers, dryers, washing machines, and buffers.

- **Method of Depreciation**: The straight-line method of depreciation is the only acceptable method of depreciation. Under this method the annual allowance is determined by dividing the cost of the asset (less any estimated salvage value) by the years of useful life. This method produces a uniform allowance each year.

- 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.

- The provider must adjust out any equipment, major or minor, if it is of any type that is not included in the rate paid to nursing facilities.

- Amortization costs should be expensed at the cost center where the particular expense would have been categorized if it had been expensed as an ordinary business expense (i.e.: it is **not** automatically a capital related cost). If it cannot be determined where the amortized expenses properly belong, the amortization expense should be categorized as an administrative expense.

106. through 109. Other - any other capital related expenses not provided for above or in the operating cost center. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

110. Total capital cost center costs – enter the sum of lines 101 through 109 for columns 1 through 4.

NON-MEDICAID ANCILLARY HEALTH CARE COSTS

111. Ancillary Salaries - gross wages for any employees of the provider that provide ancillary services that are not normally covered in the daily Medicaid rate, but are provided on a charge basis.

112. Allocation of Employee Benefit Costs – enter the amount from Worksheet E-1, line 5, column 4 that represents that portion of employee benefit costs applicable to total ancillary salaries.

113. through 123. Ancillary Services - fees paid for contracted services and supplies used in providing ancillary services which are not part of the Medicaid daily rate for any level of care. These services are normally provided on a charge basis. This includes therapy

services, private physician services, prescription drugs, certain lab and x-ray charges, central supply and other durable medical equipment. Medicaid pays for allowable ancillaries directly to the provider.

124. Total Non-Medicaid Ancillary Health Care Costs – enter the sum of lines 111 through 123 for columns 1 through 4.

OTHER CARE AND NON-REIMBURSABLE EXPENSES

125. Salaries - Non-Reimbursable Cost Center - gross salaries for any employees of the provider that perform non-reimbursable activities (i.e. marketing personnel) or provide direct care for "other" levels of care not paid by the Medicaid program (i.e. assisted living, group care).

126. Allocation of Employee Benefit Costs – enter the amount from Worksheet E-1, line 6, column 4 that represents that portion of employee benefit costs applicable to total other care and non-reimbursable salaries.

127. Advertising/Public Relations - costs that seek to increase patient utilization of the provider's facilities are not allowable. This includes fund-raising costs, promotional advertising, physician recruitment and public relations. See Provider Reimbursement Manual, HIM 15, Part I, Section 2136 for more specific information.

128. Bad Debt/Collection Expense - bad debt expense is non-allowable and must be adjusted out. Bad debts, charity, and courtesy allowances are considered deductions from revenue and are not to be included in allowable costs. See Provider Reimbursement Manual, HIM 15, Part I, Sections 300 and 310 for more specific information.

129. Fines and Penalties - fines and penalties of any kind are non-allowable costs and must be adjusted out.

130. Income Tax Expense - certain taxes that are levied on providers are not allowable costs. These taxes include:

- Federal income and excess profit taxes, including any interest or penalties paid thereon (see HIM 15-1, § 1217).
- State or local income and excess profit taxes (see HIM 15-1, § 1217).
- Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bonds, property transfers, and issuance or transfer of stocks, etc. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as tax expense.

- Taxes from which exemptions are available to the provider.
- Special assessments on land which represent capital improvements such as sewers, water, and pavements should be capitalized and depreciated over their estimated useful lives.
- Taxes on property that is not used in rendering covered services.
- Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider.
- Self-employment (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture, etc.

131. Allocation of Operating Costs - enter the amount calculated on Worksheet E-2, line 4, column 4 that represents that portion of general service (operating) costs allocated to non-reimbursable care from the operating cost center based on patients day by level of care.

132. through 134. Other - any "other" care or non-reimbursable expenses not provided for above. If the total amount reported exceeds $1,000, identify in the spaces provided and/or attach a separate schedule.

135. Total Other Care and Non-Reimbursable Costs – enter sum of lines 125 through 134 for columns 1 through 4.

136. Total Expenses – enter the sum of all the cost center totals to include line 57, line 65, line 76, line 88, line 100, line 110, line 124 and line 135 for columns 1 through 4.

137. Net Income (Loss) – enter sum total of Worksheet C-2, line 21 (total revenues) less Worksheet C-3, line 136 (total expenses) for columns 1 through 4.

PG. 16 - 18: WORKSHEET D-1 -- EXPENSE ADJUSTMENTS

This Worksheet is provided in order to make adjustments that affect only expense accounts. For reclassifications affecting more than one account or affecting balance sheet and revenue accounts, use Worksheet D-2. Some of the items, which must be adjusted, are listed under the appropriate cost centers on Worksheet D-1. Other items to be eliminated are those expenses specifically that do not meet the test of "reasonable, necessary and proper" as defined in the Provider Reimbursement Manual (CMS Pub 15-1).

Each adjustment must be identified by a number and must have an explanation of the reason for the adjustment.

COLUMN 1: Enter the number of the adjustment.

COLUMN 2: Enter the Worksheet C-3 line number(s) on which the adjustment appears.

COLUMN 3: Listed are the more common adjustments made to provider expenses. Any additional adjustments the provider is required to make must be explained on the lines provided.

COLUMN 4: Enter the amount of the adjustment with credits being indicated by brackets or a minus sign.

Costs that are allocations from Worksheet E-1 and E-2 should also be reported on worksheet D-1, column 2 where indicated. Other adjustments must be entered manually on the appropriate line of Worksheet C-3.

For each cost center, the adjustments are to be totaled. "Total adjustments to allowable costs" at the end of Worksheet D-1 should agree to the sum total on Worksheet C-3, line 136, column 2.

PAGES 19 - 20: WORKSHEET D-2 -- ADJUSTMENTS AND RECLASSIFICATION

All adjustments on Worksheets C-1 (Balance Sheet) or C-2 (Revenues), column 2 must be supported by adjustments on Worksheet D-2. Each adjustment must be identified by a number and must have an explanation of the reason for the adjustment. Use as many copies of Worksheet D-2 as necessary to list all required adjustments.

COLUMN 1: Enter the number of the adjustment continuing with the next number following the last one used on Worksheet D-1. (Example: If last adjustment number used on Worksheet D-1 was adjustment 12, Worksheet D-2 should begin with adjustment 13.)

COLUMN 2: Enter the Worksheet to which the adjustment applies.

COLUMN 3: Enter the line number to which the adjustment applies.

COLUMN 4: State what and why an adjustment is necessary. Be specific as to the reason for the adjustment.

COLUMN 5: Enter the amount(s) of the adjustment, with credits indicated by brackets or a minus sign.

Enter page totals for each page of Worksheet D-2.

PAGE 21: WORKSHEET D-3 -- COST OF SERVICES FROM RELATED ORGANIZATIONS

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Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are included in the allowable costs of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining.

This Worksheet provides for the computation of any needed adjustments to costs furnished to the provider by organizations related to the provider. In addition, certain information concerning the related organizations with which the provider has transacted business must be shown (see Provider Reimbursement Manual HIM15-I, chapter 10).

A determination as to whether an individual (or individuals) or organization possesses significant ownership or equity in the provider organization and the supplying organization, so as to consider the organizations related by common ownership, will be made on the basis of the facts and circumstances in each case. This rule applies whether the provider organization or supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (e.g., a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

- Related to the provider means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies.

- Common ownership exists when an individual or individuals possess significant ownership or equity in the provider and the institution or organization serving the provider.

- Control exists where an individual, or an organization, has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

PART A: Indicate if any transactions occurred between related organizations. Complete parts B and C only if such transactions have occurred.

PART B: Use this part to identify the costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider. However, such cost must not exceed the amount a prudent and cost conscious buyer would pay for comparable services, facilities, or supplies that could be purchased elsewhere.

Column 1 Enter the line numbers where costs are included on Worksheet C-3.

Column 2 Use this column to identify the nature of the expense items.

Column 3 Enter the amount reported in the trial balance and/or general ledger of the provider and included on Worksheet C-3, column 1.

Column 4 Enter the amount of cost that is considered allowable based on the actual costs of the related organization. Supporting calculations and/or documentation should be included with the cost report filing.

Column 5 Enter the adjustment amount as the difference between column 3 and column 4. This amount should be carried to the appropriate cost center on Worksheet D-1 and to the appropriate line number on Worksheet C-3, column 2.

PART C: Use this part to show the interrelationship of the provider to organizations furnishing services, facilities, or supplies to the provider. The requested data relative to all individuals, partnerships, corporations, or other organizations having either a related interest to the provider, a common ownership of the provider, or control over the provider must be shown in columns 1 through 6, as appropriate.

Complete only those columns that are pertinent to the type of relationship that exists. Provide all information requested concerning the relationship to the provider.

Column 1 Enter the appropriate symbol which describes the interrelationship of the provider to the related organization.

Column 2 If the symbols A, D, E, F, or G are entered in column 1, enter the name of the related individual in column 2.

Column 3 If the individual indicated in column 2 or the organization indicated in column 4 has a financial interest in the provider, enter the percent of ownership in the provider.

Column 4 Enter the name of the related corporation, partnership, or other organization.

Column 5 If the individual indicated in column 2 or the provider has a financial interest in the related organizations, enter the percent of ownership in such organization.

Column 6 Enter the type of business in which the related organization engages (e.g., medical drugs and/or supplies, laundry, and linen service).

At the bottom of the Worksheet enter the name and address of the home office intermediary.

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PAGE 22: WORKSHEET E-1 – ALLOCATION OF EMPLOYEE BENEFIT COSTS

This Worksheet is intended to allocate the cost of employee benefits to each cost center based on the gross salaries charged to those cost centers. Gross salaries come from Worksheet C-3 lines as indicated. Employee benefit costs come from Worksheet C-3, lines 58 to 63, columns 1 through 4. The adjusted employee benefit costs from line 14, column 4 are allocated to each cost center based on the gross salaries as a percentage of total salaries.

PART I, Column 1-

LINE 1: Enter the total Operating Salaries from Worksheet C-3, column 1, line 16.
LINE 2: Enter the total Direct Health Care Salaries from Worksheet C-3, column 1, line 71.
LINE 3: Enter the total Non-Pediatric Ventilator Care Salaries from Worksheet C-3, column 1, line 80.
LINE 4: Enter the total Pediatric Specialty Care Salaries from Worksheet C-3, column 1, line 93.
LINE 5: Enter the total Ancillary Salaries from Worksheet C-3, column 1, line 111.
LINE 6: Enter the total Other-Care and Non-Reimbursable Salaries from Worksheet C-3, column 1, line 125.
LINE 7: Enter the sum of lines 1 through 6.

PART I, Column 2 -

Calculate the percentage for lines 1 through 7 by dividing the amount of each salary line (column 1) by the total salary amount on line 7.

PART I, Column 4 –

Calculate the allocation to each cost center by multiplying the total adjusted balance of employee benefit costs (Part II, line 14, column 4) by the percentage of each respective line from column 2.

LINE 1: Transfer this amount to worksheet C-3, line 41, column 2 and the appropriate line on Worksheet D-1.
LINE 2: Transfer this amount to worksheet C-3, line 75, column 2 and the appropriate line on Worksheet D-1.
LINE 3: Transfer this amount to Worksheet C-3, line 86, column 2 and the appropriate line on Worksheet D-1.
LINE 4: Transfer this amount to Worksheet C-3, line 98, column 2 and the appropriate line on Worksheet D-1.
LINE 5: Transfer this amount to Worksheet C-3, line 112, column 2 and the appropriate line on Worksheet D-1.
LINE 6: Transfer this amount to Worksheet C-3, line 126, column 2 and the appropriate

line on Worksheet D-1.

LINE 7: Enter the sum of lines 1 through 6 and transfer this amount as a **negative** to Worksheet C-3, line 64, column 2 and the appropriate line on Worksheet D-1.

PART II, Columns 1 through 4 –

LINE 8: Enter the amount from Worksheet C-3, line 58 for each column.
LINE 9: Enter the amount from Worksheet C-3, line 59 for each column.
LINE 10: Enter the amount from Worksheet C-3, line 60 for each column.
LINE 11: Enter the amount from Worksheet C-3, line 61 for each column.
LINE 12: Enter the amount from Worksheet C-3, line 62 for each column.
LINE 13: Enter the amount from Worksheet C-3, line 63 for each column.
LINE 14: Enter the sum of lines 8 through 13 for each column 1 through 4. This is the total of allocable employee benefits. Line 14, column 4 is the amount to be allocated to the individual cost centers and should equal the amount on line 7 column 4.

PAGE 23: WORKSHEET E-2 – ALLOCATION OF OPERATING COSTS

This Worksheet allocates the operating costs to cost centers based on the number of patient days for the level of care within the cost center. This Worksheet is intended for those facilities that provide non-pediatric ventilator, pediatric specialty or other levels of care. For those who only provide basic care, this Worksheet need not be used.

Total patient days come from Worksheet B. Operating costs come from Worksheet C-3, lines 16, 42, and 55, columns 1 through 4. The adjusted operating costs from line 9, column 4 are allocated to each cost center based on the level of care patient days as a percentage of total patient days.

PART I, Column 1-

LINE 1: Enter the Basic Care total patient days from Worksheet B, column 3, line 6.
LINE 2: Enter the Non-Pediatric Ventilator Care total patient days from Worksheet B, column 3, line 7.
LINE 3: Enter the Pediatric Specialty Care total patient days from Worksheet B, column 3, line 8.
LINE 4: Enter the Other Care total patient days from Worksheet B, column 3, line 9.
LINE 5: Enter the sum of lines 1 through 4.

PART I, Column 2 -

Calculate the percentage for lines 1 through 5 by dividing the amount of each level of care line (column 1) by the total patient days on line 5.

PART I, Column 4 –

Calculate the allocation to each cost center by multiplying the adjusted balance of operating costs (Part II, line 9, column 4) by the percentage of each respective line from column 2.

LINE 1: Transfer this amount to worksheet C-3, line 56, column 2 and the appropriate line on Worksheet D-1.

LINE 2: Transfer this amount to worksheet C-3, line 87, column 2 and the appropriate line on Worksheet D-1.

LINE 3: Transfer this amount to worksheet C-3, line 99, column 2 and the appropriate line on Worksheet D-1.

LINE 4: Transfer this amount to worksheet C-3, line 131, column 2 and the appropriate line on Worksheet D-1.

LINE 5: Enter the sum of lines 1 through 4 and transfer this amount as a **negative** to Worksheet C-3, line 56, column 2 and the appropriate line on Worksheet D-1.

PART II, Columns 1 through 4 –

LINE 6: Enter the amount from Worksheet C-3, line 16 for each column.

LINE 7: Enter the amount from Worksheet C-3, line 42 for each column.

LINE 8: Enter the amount from Worksheet C-3, line 55 for each column.

LINE 9: Enter the sum of lines 6 through 8 for each column 1 through 4. Line 9, column 4 is the amount be allocated to the individual cost centers and should equal the amount on line 5 column 4.

PAGE 24: WORKSHEET E-3 – ALLOCATION OF CAPITAL COSTS

This Worksheet provides for the allocation of capital costs to cost centers. The basis for allocation is the number of patient days for the level of care within the cost center. This Worksheet is intended for those facilities that provide non-pediatric ventilator, pediatric specialty or other levels of care. For those who only provide basic care, this Worksheet need not be used.

Total patient days come from Worksheet B. Capital costs come from Worksheet C-3, lines 101 through 109, columns 1 through 4. The capital cost allocation is used only for the summary of cost centers at Worksheet H. No allocation is made by way of an adjustment to Worksheet C-3. The adjusted capital costs from line 15, column 4 are allocated to each cost center based on the level of care patient days as a percentage of total patient days.

PART I, Column 1-

LINE 1: Enter the Basic Care total patient days from Worksheet B, column 3, line 6.

LINE 2: Enter the Non-Pediatric Ventilator Care total patient days from Worksheet B, column 3, line 7.
LINE 3: Enter the Pediatric Specialty Care total patient days from Worksheet B, column 3, line 8.
LINE 4: Enter the Other Care total patient days from Worksheet B, column 3, line 9.
LINE 5: Enter the sum of lines 1 through 4.

PART I, Column 2 -

Calculate the percentage for lines 1 through 5 by dividing the amount of each level of care line by the total patient days on line 5.

PART I, Column 4 –

Calculate the allocation to each cost center by multiplying the total adjusted balance of capital costs (Part II, line 15, column 4) by the percentage of each respective line from column 2.

LINE 1: Transfer this amount to Worksheet H, line 4, column 1.
LINE 2: Transfer this amount to Worksheet H, line 4, column 2.
LINE 3: Transfer this amount to Worksheet H, line 4, column 3.
LINE 4: Transfer this amount to Worksheet H, line 4, column 5.
LINE 5: Enter the sum of lines 1 through 4.

PART II, Columns 1 through 4 –

LINE 6: Enter the amount from Worksheet C-3, line 101 for each column.
LINE 7: Enter the amount from Worksheet C-3, line 102 for each column.
LINE 8: Enter the amount from Worksheet C-3, line 103 for each column.
LINE 9: Enter the amount from Worksheet C-3, line 104 for each column.
LINE 10: Enter the amount from Worksheet C-3, line 105 for each column.
LINE 11: Enter the amount from Worksheet C-3, line 106 for each column.
LINE 12: Enter the amount from Worksheet C-3, line 107 for each column.
LINE 13: Enter the amount from Worksheet C-3, line 108 for each column.
LINE 14: Enter the amount from Worksheet C-3, line 109 for each column.
LINE 15: Enter the sum of lines 6 through 14 for each column 1 through 4. This is the total of allocable capital costs.

PAGE 25: WORKSHEET F-1A – MAJOR RENOVATION/REMODEL PROJECTS

The Fair Rental Value (FRV) reimbursement system has been used to determine each facility's capital rate since July 1, 2003. Current Regulations regarding the determination of Fair Rental Value are contained in Attachment C to these instructions. Facility specific FRV rates can be found at the Division's website (http://dhcfp.state.nv.us/RatesUnit.htm). The purpose of the F-1 Worksheets is to identify major renovation/remodel projects that were completed and placed in service during the cost reporting period and may affect (increase) the FRV rate. Projects must

meet the following criteria to be eligible for inclusion in the FRV rate:

- Projects placed in service prior to July 1 must be reported to the Division of Health Care Financing and Policy (DHCFP) prior to May 1 to be included in the FRV rate effective July 1.
- Projects may be no more than 24 months in duration.
- Projects must be documented within the provider's depreciation schedules.
- The allowable cost of projects that do not add licensed beds must exceed $1,000. per licensed bed.
- Projects that add licensed beds are not subject to the $1,000. per licensed bed threshold.

LINE 1: Answer "Yes" if a project meeting the above criteria was placed in service during the cost reporting period. If more than one eligible project was placed in service, complete a separate F-1 worksheet for each. Identical Worksheets F-1A, F-1B and F-1C are provided for reporting one to three projects. If no eligible project was placed in service, answer "No" and skip to Worksheet G-1.

LINE 2: Answer "Yes" if the project was placed in service and reported to DHCFP. Answer "No" if the project was placed in service but not reported to DHCFP.

LINE 3: Provide the date in mm/dd/yyyy format when the project was reported to DHCFP. Answer "N/A" if it was not previously reported.

LINE 4: Provide the total cost of the project that was previously reported to DHCFP. These may have been estimated costs for projects reported prior to their in-service dates.

LINE 5: Answer "Yes" if the project increased the number of licensed beds that existed at the beginning of the cost reporting period. Answer "No" if the project did not increase the number of licensed beds. If the answer was "No," skip to Line 8.

LINE 6: If the answer on Line 5 was "Yes," provide the date in mm/dd/yyyy format when the added beds were certified for Medicaid. Answer "N/A" if the beds have not been certified for Medicaid.

LINE 7: Answer "Yes" if the added beds are included on Lines 2 and 3 of Worksheet B. Answer "No" if the additional beds are not included on Worksheet B.

LINE 8: Answer "Yes" if the assets added in the project were included on the facility's depreciation schedules for the cost reporting period. Answer "No" if the assets have not been included on the current year's schedules.

LINE 9: Provide a brief description or name identifying the nature and location of the project, e.g., "south wing extension."

LINE 10: In Column 1 enter the sum of all the costs claimed on the cost report that are related to the project. The sum may differ from the amount shown on Line 4 that was previously reported to DHCFP. In Column 2 enter the total number of licensed beds at the end of the cost reporting period. Column 2 fills automatically from Worksheet B, Line 3, Column 5. In Column 3, enter the cost per licensed bed by dividing the cost in Column 1 by the number of beds in Column 2. Round to the nearest whole dollar. Column 3 calculates automatically.

LINE 11: Reserved for Cost Settlement and Audit Contractor's audit adjustments. Make no entries on this line.

LINE 12: In Columns 1, 2 and 3, enter the sum of the respective columns from lines 10 and 11. Line 12 calculates automatically.

PAGE 26: WORKSHEET F-1B – MAJOR RENOVATION/REMODEL PROJECTS

This worksheet is similar to F-1A, and is included to allow for identification of a second project put in service during the cost reporting period. Refer to instructions for Worksheet F-1A.

PAGE 27: WORKSHEET F-1C – MAJOR RENOVATION/REMODEL PROJECTS

This worksheet is similar to F-1A/B, and is included to allow for identification of a third project put in service during the cost reporting period. Refer to instructions for Worksheet F-1A.

PAGE 28 - 30: WORKSHEET G-1 – DIRECT HEALTHCARE COST ADJUSTMENT

The direct care cost center includes allowable RN, LPN, and Nursing Aide salaries and wages; a proportionate allocation of allowable employee benefits; and the direct allowable cost of acquiring RN, LPN and Nurse Aide staff from outside staffing companies. A facility-specific price is established for this cost center based on 110% of the statewide Medicaid day weighted median. However, a minimum direct care-staffing requirement applies in order to encourage adequate direct care staffing.

Effective for cost reporting periods beginning after July 17, 2003, if a nursing facility does not incur direct care costs that equal at least the Adjusted Total Facility Specific Health Care Floor (line 8b), the Department will have the option to recoup from future Medicaid payments to that provider an amount equal to 100% of the spread between the provider's direct care payments and the actual cost the provider incurred. The

repayment amount, if it applies, is calculated by this worksheet and appears on line 10.

Part I – Direct Health Care Cost Center

LINE 1: Enter the amount from Worksheet C-3, line 76 for each column. This is the total of the direct health care cost center.

Part II – Computation of Minimum Direct Care Staffing Requirement

LINE 2: Enter the amount from line 1, column 4.

LINE 3: Enter the total adjusted Nursing Facility Standard Care patient days from Worksheet B line 6, column 3.

LINE 4: Calculate the provider health care costs per-patient day by dividing line 2 (adjusted direct health care costs) by line 3 (total basic care patient days). Round to the nearest cent.

LINE 5: Enter the total adjusted Nevada Medicaid Nursing Facility Standard Care patient days from Worksheet B line 6, column 6.

LINE 6: Calculate the total Medicaid Direct Care Costs by multiplying line 4 (per-patient day health care costs) times line 5 (Nevada Medicaid NF days).

LINE 7: Enter the total Medicaid Direct Health Care Payments from Worksheet G-1 line 26, column 5. (Part III on this worksheet must be completed first.)

LINE 8: Enter the Adjusted Direct Healthcare Floor Dollar Minimum from Worksheet G-1 line 42, column 8. (Part IV on this worksheet must be completed first.)

LINE 9: Determine the difference between the direct care costs and the minimum direct care staffing requirement by subtracting line 8 from line 6. If this is a positive number, then the provider has met the requirements of providing adequate direct care staffing and zero may be entered on line 10.

LINE 10: If line 9 is a negative number, then the minimum staffing requirement has not been met and the provider should calculate the difference between the direct health care payments (line 7) and the total Medicaid direct care costs (line 6). This amount is then carried to the submission checklist and entered in the appropriate box as an amount due to the Nevada Medicaid Program.

Part III – Computation of Direct Health Care Payments

LINES 12 through 25:

Column 1: Enter each month/year included in the audit period.

Column 2: Enter the number of NF Standard Care Days provided during the month for which Nevada Medicaid paid. Days paid are found on the CRS Report listings distributed by the Cost Settlement and Audit Contractor.

Column 3: Enter the Facility Specific Direct Care Price applicable to the facility for the month. Prices for the applicable time periods are found on the Rates Calculation Worksheets on the website of the Division of Health Care Financing and Policy (http://www.dhcfp.state.nv.us/RatesUnit.htm).

Column 4: Enter the Budget Adjustment Factor for the month. Adjustments for the applicable time periods are found on the same report used for Column 4 above.

Column 5: Calculate NF Standard Care Direct Health Care Payments for each month by multiplying days from Column 2 by the direct care price from Column 3 and the budget adj. factor from Column 4..

LINE 26: **Column 5:** Calculate total NF Standard Care Direct Health Care Payments for the audit period by summing the amounts from Lines 12 through 25. Transfer the total to Line 7.

Part IV -- Computation Of Facility Specific Health Care Floor

LINES 28-41: **Column 3:** Enter the Direct Care Floor amount for each month using the amounts on the Rates Calculation Worksheet also used for lines 11 – 25.

Column 4: This column is for retroactive payments adjustments that will be provided to the Cost Settlement and Audit Contractor by the Division of Health Care Financing and Policy.

Column 5: Enter the Provider Tax Per Diem Rate which can be obtained from the monthly reports titled "Nursing Facilities Monthly Report and Fee Assessed to Increased the Quality of Nursing Care" which are submitted to the Division of Health Care Financing and Policy.

Column 6: Enter the taxable days reported on the same report used for column 5.

Column 7: Calculate this column by multiplying columns 5 & 6.

Column 8: Calculate this column by multiplying columns 2, 5, & 12.

Column 9: Calculate this column by subtracting column 8 from column 7. Divide that total by 2 and then multiply by 41% (0.41).

Column 10: Calculate this column by adding columns 3, 4, & 9.

Column 11: Calculate this column by multiplying columns 2 & 10.

Column 12: Enter the Budget Adjustment Factor using the amounts from Lines 12 to 25 Column 4.

Column 13: Calculate this column by multiplying columns 11 & 12.

LINE 42 **Column 13:** Calculate the Adjusted Direct Healthcare Floor Dollar Minimum by summing the amounts in lines 28 through 41. Transfer the total to line 8.

PAGE 31: **WORKSHEET H – COST REPORT SUMMARY**

This Worksheet is provided as a summary comparison of Medicaid costs and payments for informational use only. There is no settlement under the prospective payment system currently in effect. This page summarizes the various costs associated with providing each level of care.

LINE 1: Operating Costs - Enter the amount for each level of care from Worksheet E-2.

LINE 2: Employee Benefit Costs - Enter the amount for each level of care from Worksheet E-1. For the NF Standard Care, include employee benefits allocated to both operating salaries and direct care health care salaries (Worksheet E-1, Column 4, lines 1 and 2).

LINE 3: Direct Care Costs – Enter the amount of the direct care costs as follows:

Column 1: sum lines 71 through 74 of Worksheet C-3 (column 4).
Column 2: sum lines 80 through 85 of Worksheet C-3 (column 4).
Column 3: sum lines 93 through 97 of Worksheet C-3 (column 4).

LINE 4: Capital Costs – Enter the amount for each level of care from Worksheet E-3.

LINE 5: Enter the sum of lines 1 through 4 columns 1 through 5.

LINE 6: Enter the total days for the period covered by this cost report from Worksheet B lines 6 through 9, column 3.

LINE 7: Divide line 5 by line 6 for each column.

LINE 8: Enter Medicaid days for the period covered by this cost report from Worksheet B, lines 6 through 9, column 6.

LINE 9: Multiply line 7 by line 8 to arrive at the allowable Medicaid cost for each level of care.

LINE 10: Enter interim payments from all sources for the Medicaid days shown on line 8. This includes claims payments, lump-sum payments for retroactive rate adjustments, and any other payments made for allowable facility costs.

LINE 11: Enter the result of line 9 less line 10 in all columns.

LINE 12: Enter the sum of columns 1 through 5, line 11.

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Attachment A

Nursing Supplies

Examples of nursing supplies are as follows:

ABD pads
Ace bandage
Adhesive tape
Antacids
Antiseptics
Applicators
Arm slings
Autoclave tape
Baby powder
Band-Aids
Bandages
Bedside tissues
Benzoin compounds
Butterfly closures
Cannula catheters
Catheter sets or trays
Clysis set
Coloplast
Combs
Cotton swab
Decubitus pads
Denture cream
Dermassage
Diabetic test tapes or tablets
Diapers
Disposable bags, enema cans, tissues or under pads
Douche supplies
Drainage bag or set or tubing
Dressings
Egg crate padding
Finger cots
Fleets enema
Flex straws
Foleys
Foot powders
Gastric tubes
Gloves
Hairbrushes
Harris flush tube
Heel protector
Invalid ring
Iodine
Irrigation set or solution or tray
IV set or solution
K-pads
Kleenex
Kling bandage
KY jelly
Laxatives
Levine tube
Lotions
Lubricating jelly
Maalox
Medicine cups or droppers
Mercurochrome
Merthiolate
Milk of magnesia
Mineral oil
Mouthwash
Needles
Non-allergenic tape
Non-legend drugs and biologicals
Ointments
Ostomy supplies
Peroxide
Q-tips
Razors
Rubbing alcohol
Sani-pants and liners
Scalpel
Shampoo
Shaving cream
Sheepskins
Soap
Specimen bottles or cups
Sterile pads or sponges
Suppositories
Surgical dressings
Surgical pad or tape
Suture set or tray
Swabs
Syringes
Tape
Thermometers
Tongue blades
Toothbrushes
Toothpaste
Tubing of all types and uses
Urological solution
Vaseline
Vitamin or mineral preparations

The charges paid by facilities must be "reasonable" and may not exceed the supplier's usual charge to the general public. Reasonableness requires the amount charged to be such as would be paid for comparable goods or services by comparable institutions. In all cases, non-legend drugs can be bought at a lower price if purchased in bulk versus on a per-patient basis. It would be impractical and expensive, however, to insist that all non-legend drugs be purchased on a bulk basis due to a lack of demand for some items.

If a facility employs a unit-dose delivery system, all non-legend drugs given on a "PRN" (as needed) basis should be bulk-purchased and excluded from the unit-dose system in order to conserve funds. This would exclude aspirin, acetaminophen (Tylenol), house laxatives, etc. from the unit-dose delivery system. If a non-legend drug is given on a routine daily schedule (e.g., daily multivitamins) a unit-dose system may be employed but cost versus benefit should be examined.

Nutritional supplements (Ensure, Sustacal) are not an allowable routine cost either as food or a nursing supply. These costs should be recorded on line 122 of Worksheet C-3 as other non-Medicaid ancillary cost.

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COST REPORT INSTRUCTIONS

Attachment B

New Facilities

Start-Up Costs:

For a newly constructed facility, operating costs incident to the start of business (salaries, electricity, office supplies, etc.), are accumulated and amortized as of the "date the first resident is admitted". This resident does not have to be a Medicaid Recipient. The accumulation of these costs begins as of the date of the "Certificate of Occupancy". For a leased facility, the accumulation of these costs begins when the facility is ready for occupancy. The amortization period is 60 months. Allowable amortization expense for Medicaid reimbursement does not begin until the facility is Medicaid certified.

If a facility is sold before all start up costs have been fully amortized, either the new owner (buyer) can continue to amortize the start up costs if he pays the seller for them, or the seller may expense all remaining amortization costs on his/her final cost report.

New Facilities

When a new facility is constructed, its property costs for depreciation purposes will be recognized up to limits set for various key factors. These limits are:

a. Cost per bed - The most current applications for the Certificate of Need will be used to provide data on construction cost per bed. Beginning July 1, 2003, the cost per bed is set at $73,000. Each year this amount will be either indexed forward using the nursing home component of the Marshal Valuation Service or recalculated from new data.

b. Financing - Eighty percent of the allowable Medicaid cost of the facility may be financed at a rate not to exceed the average prime rate in effect at the time of financing plus three percentage points.

c. Land per bed - .04 of an acre

d. Square footage per bed - 400 square feet

New facilities will receive an interim FRV rate based on the new bed value at the date of completion. Retroactive adjustments may be necessary after proper costs have been determined to compensate for over or underpayment.

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Attachment C

State Regulations Regarding Fair Rental Value (FRV)

Beginning July 1, 2003, the fair rental value (FRV) reimbursement system will be used to determine each facility's capital rate.

The following items that are set by State Regulations as of 7/1/03 will be used in determining each facility's FRV rate:

i. The value of new beds at 7/1/03 will be $73,000.

ii. The bed value will be indexed annually using the Marshal Swift, class C nursing facility index for the Western District.

iii. The rate of depreciation per year has been determined to be 1.5% per year.

iv. The maximum age in years will be 40.

v. The rental rate has been determined to be 9% annually.

vi. The minimum occupancy percentage has been determined to be 92%.

vii. The rate of depreciation per year for renovation/replacement projects has been determined to be 4% per year.