

STATE OF INDIANA
FAMILY AND SOCIAL SERVICES ADMINISTRATION
OFFICE OF MEDICAID POLICY AND PLANNING

Instructions for the Medicaid Nursing Facility Financial Report

GENERAL INSTRUCTIONS

These instructions are for use under the provisions of the rate setting criteria for nursing facilities (405 IAC 1-14.6) that are certified as Medicaid providers by the State of Indiana, Family and Social Services Administration, Office of Medicaid Policy and Planning (OMPP).

Forms and Information Forms are available from the rate setting contractor at the address below, but providers are requested to reproduce copies locally whenever possible. Information may be obtained by calling 317-846-9521 or 800-877-6927. Computerized alternatives to the Nursing Facility Financial Report prescribed by OMPP must receive prior approval before they will be accepted. Contact the rate setting contractor for the approval process. Completed financial reports should be filed with the rate setting contractor on or before the due date.

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Refer to Criteria - Instructions Are Not Comprehensive These instructions are not intended to be comprehensive. In completing the forms, providers should rely on the criteria as well as other relevant rules and regulations, including generally accepted accounting principles (GAAP).

Suggested Filing Format The forms are used for various filings with the rate setting contractor under provisions of the criteria. It is recommended that a cover letter, outlining the nature of the filing or request, accompany all forms. The letter should indicate the documents submitted and convey other information or schedules to support the filing. All financial data, except per diem information, should be rounded to the nearest whole number or dollar. The information below outlines the types of cost report reviews that are applicable under the criteria.

- A. *Regular annual review.* Providers should submit a complete Nursing Facility Financial Report that coincides with the same time period as the provider's fiscal year for tax purposes, except where OMPP has granted the provider's request for a one-time election to use a different Medicaid reporting year in accordance with the criteria. Providers will receive a regular annual review based on the annual report. In addition to filing a Medicaid Nursing Facility Financial Report, nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written and electronic cost report (ECR) file copy of their Medicare cost report that covers their most recently completed historical reporting period. In addition, the working trial balance used to complete the Medicare cost report should be submitted with the Medicare cost report. Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office. The nursing facility financial report, written Medicare cost report and Medicare ECR diskette are due in to the office not later than the last day of the fifth (5th) calendar month after the close of the provider's reporting year. Extension of the five (5) month filing period shall not be granted.

- B. *Initial interim rate review.* Requests to establish an initial interim rate for a new operation are due on or before thirty (30) days after notification of the certification date. Under 405 IAC 1-14.6-5(a), initial interim rates will be set at the sum of the average allowable cost of the median patient day and median bed rate components.

The request for an initial interim rate shall include the following information:

1. The date the service is established for the initial interim rate.
2. Nursing Facility Quality Assessment Data Collection Form.

The Nursing Facility Quality Assessment Data Collection Form must be completed to report projected patient days from the date of certification to the first fiscal year in which the provider has six months of actual historical data. Subsequent to the first fiscal year in which the provider has six months of actual historical data the Nursing Facility Quality Assessment Data Collection Form must be completed to report actual patient days from the date of certification to the first fiscal year in which the provider has six months of actual historical data.

Results of Prior Period Audit Findings

The findings and recommendations contained in prior period field audits, or inquiry by OMPP and its audit and rate setting contractors, must be utilized in the preparation of all Nursing Facility Financial Reports in accordance with 405 IAC 1-14.6-3(d). Providers should either represent that the audit findings and adjustments were incorporated into the submitted financial report, or provide sufficient quantitative information to make any adjustments necessary to comply with the audit findings, adjustments and recommendations. Information and/or representations concerning prior period audit findings should be submitted for each deficiency, adjustment, and recommendation that pertains to the financial report submission.

Generally Accepted Accounting Principles Required

Providers are advised that, pursuant to GAAP, the criteria is considered to be a comprehensive basis of accounting. As such, adherence to GAAP is required unless specific criteria language is to the contrary. Providers should maintain the working trial balance used in completing the forms for each reporting period for a minimum of three years in accordance with 405 IAC 1-14.6-3(b). The working trial balance should not be submitted unless requested by OMPP and its audit or rate setting contractors. One principle that has great importance in conveying information on the Nursing Facility Financial Report form is full disclosure. In completing the form, attach additional schedules and explanations where necessary, to accomplish full disclosure. Full disclosure requires that a knowledgeable financial reader, after reviewing the completed forms and attachments, would not be misled. GAAP also requires accurate and consistent classification of financial information. Therefore, providers should exercise care to report all data on appropriate lines and schedules of the form. The reporting of expense amounts on inappropriate lines may be misleading to the informed financial reader.

Attach Explanations Instead of Altering Forms

The financial report should not be altered in any way. In the use of unlabeled "Other" lines, specify the nature of the item reported. If more space is needed, attach a separate schedule. Do not make two listings on a line or change the description of a line. Column headers may not be modified nor should boxes that have been blacked out on the form be utilized in submitting data. If there are circumstances in which the form does not seem appropriate to report the data in the lines available, please attach a note or schedule to explain. Lengthy or detailed work papers involving several pages normally should not be submitted with the filing, but should be retained by the provider for future reference, and should be made available when requested by OMPP and its audit or rate setting contractor.

Chain Organizations or Management Groups

Nursing facility providers that are part of a multiple facility or chain organization that report home office costs must also complete the Home Office Financial Report (Schedules P through W) in accordance with 405 IAC 1-14.6-3(f). Allocated costs that are incurred at a home office must be properly reported and submitted on the Home Office Financial Report in order to be included on the Nursing Facility Financial Report. The home office reporting period must coincide with the nursing facility reporting period. For each home office entity allocating costs to individual facilities, only one copy of the Home Office Financial Report should be submitted. Organizations with multiple home office cost allocations should submit a separate Home Office Financial Report for each home office. The cover letter for each home office should reference all nursing facilities affected by the Home Office Financial Report. For additional information, please refer to the Instructions for the Home Office Financial Report.

If the facility has entered into a management consulting agreement with a non-related party, the fees and other costs associated with the management agreement must be reported on Line 383. However, personnel costs and hours may be allocated to specific expense lines if the management agreement includes the following:

A detailed description of the services each individual is performing, the total number of individuals performing each service and the specific line of the cost report on which each service will be reported, including both costs and hours.

As required by 405 IAC 1-14.6-17(c), payroll records shall be maintained to substantiate the staffing costs reported. Records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and in which the employee worked.

Upon request during an audit by the OMPP or its audit or rate setting contractor, the actual time cards and payroll documentation, including W-2's and 941's, supporting the actual costs and hours allocated to the facility's specific expense lines must be made available.

Employee benefits associated with personnel services described above may be allocated to specific lines of the financial report. These benefits should be reported on the most descriptive expense line for each benefit provided. Detailed documentation supporting the allocation of benefits to expense lines must be made available by the facility upon request during a field audit by the OMPP or its audit or rate setting contractor.

In the event that an audit indicates that costs outlined above are not documented and supported, the costs will be reclassified to Line 383 of the financial report.

Any additional costs which are paid by the facility under the management agreement must be reported on Line 383 of the financial report.

If the facility has entered into a management consulting agreement with a related party, the fees and other costs associated with the management agreement must be reported at the cost to the related party on the appropriate expense lines and a Home Office Financial Report for Nursing Facilities should be submitted.

SPECIFIC INSTRUCTIONS

While most sections and lines of the financial report form are self-explanatory, the following additional clarification is provided.

Provider Name and Identification Data

AIM Number It is very important that the provider's AIM number be stated correctly. The incorrect reporting of an AIM number can delay the review process. Report the AIM number on every page of the financial report.

Line(s) [20101] and [20102] -- Period of Report Indicate the beginning and ending dates of the financial and statistical data.

Line(s) [13241], [13242], [13243] Indicate whether the facility is owned, operated under a capital lease or an operating lease.

Line(s) [15151] and [15152] Indicate whether the facility is licensed as a hospital based nursing facility and if the facility is registered as a continuing care retirement community in accordance with IC 23-2-4. In addition, indicate the dates that each of these designations became effective and when they were terminated, if applicable.

Schedule A -- Statistical Data

Line 142 -- Beds Available Providers must allocate applicable financial and statistical data, including the number of beds, between the nursing facility and other beds. All data reported in the financial report must be consistent with the number of beds reported in Schedule A.

Column [01] must include all Medicaid certified, Medicare certified, and dual licensed Medicare/Medicaid nursing facility beds. MDS assessments must be electronically transmitted to the state for residents in these beds (coded as a 3 in the SUB_REQ field). Non-certified comprehensive care beds must be included in Column [01] when the MDS assessments for these residents have been transmitted to the state and coded as a 2 in the SUB_REQ field.

All beds not included in Column [01] should be reported in Other Nursing, Column [03] or Other, Column [04]. Column [03] – Other Nursing should include all non-certified comprehensive care beds (licensed nursing facility beds) in which MDS assessments were not transmitted electronically to the state. If a provider reports these beds as “Other Nursing,” these assessments need not be electronically transmitted to the state or transmitted and coded as a 1 in the SUB_REQ field. Column [04] – Other should include all beds not licensed as nursing facility beds such as assisted living and residential beds.

If the number of licensed beds changed during a reporting period, the number of beds reported on the Financial Report should be a weighted average of the number of beds licensed during the reporting period.

Line 143 -- Bed Days Available Total bed days available should equal the number of beds reported multiplied by the number of days in the reporting period. If the number of licensed beds changed during the reporting period, the bed days available should be a weighted average using the number of licensed beds from each portion of the reporting period.

Lines 144, 145 and 148 -- Patient Days The number of patient days should be based on census logs maintained by the provider. The number of days reported must agree to those reported on Schedule I -- Summary of Occupant Days.

Line 153 -- Total Hours Worked During Period The total on Line 153, Columns [01], [03] and [04] should equal the total of Schedule E, Line 498, Column [01] (Grand Total). If not, a reconciliation and full explanation must be provided on a separate attachment.

Schedule C -- Schedule of Charges

Schedule C should be completed on all financial reports submitted. Column [01] should reflect the lowest usual and ordinary charge for private pay nursing facility residents for like levels of services in effect at the report year end (RYE). Providers should complete Column [01] on all applicable room configuration lines.

Schedule D -- Schedule of Revenue

Schedule D should disclose all revenues from the facility's operation, and should reconcile to the provider's financial records, including the working trial balance. Routine and ancillary revenues from all payor sources should be reported on the appropriate lines and columns. Income that should be offset against a related expense must also be reported, and question [26810] should be answered at the bottom of Schedule D. Submit a schedule detailing the Schedule E line number(s) against which these revenues should be or have been offset.

The revenues reported in Column [06] (Total) should be allocated between Columns [07] (Nursing Facility) and [08] (Other) based upon the gross amount charged to each resident classification. For example, if an assisted living resident generates gross charges for routine daily service, the associated revenues should be reported in Column [08] (Other). Revenues for both Other Nursing Beds and Other Beds should be combined and reported in Column [08] (Other). In addition, any outpatient therapy revenues should be reported in Column [08] (Other).

Line 211 -- Routine Daily Service Routine daily service revenue should be reported in the appropriate columns as gross revenue by the primary payor source (i.e., if the primary payor is Medicare and the Medicaid program pays for co-insurance, then the gross routine service revenue should be reported in the Medicare column).

Lines 231, 232, 233, 234, 236 and 239 -- Physical Therapy, Speech and Audiology Therapy, Occupational Therapy, Respiratory Therapy, Sale of Non-Routine Medical Supplies and Parenteral and Enteral Nutrition (PEN) Therapy revenue, non-routine medical supply revenue, and Parenteral and Enteral Nutrition (PEN) should be reported in the appropriate column by actual payment source (i.e., Medicaid, Medicare Part A and Part B, Private Pay or Other). Although the criteria requires therapy, non-routine medical supply items, and Parenteral and Enteral Nutrition (PEN) items to be reimbursed through the per diem rate, revenue for Medicaid therapy services, Medicaid non-routine medical supplies, and Medicaid Parenteral and Enteral Nutrition (PEN) items should be reported on Lines 231, 232, 233, 234, 236 and 239 using gross charges consistently applied to all payer types. The total amount of the Medicaid therapy, non-routine medical supply, and Parenteral and Enteral Nutrition (PEN) should then be netted to zero with a contractual adjustment on Line 263 (Less Contractual/Charity Allowances). Therapy revenue for providing services on an outpatient basis should be reported on the appropriate lines 231, 232, 233 and 234 in columns [05] and [08]. This revenue should be offset or the actual costs removed through an adjustment in column 24 against the corresponding expense line on Schedule E lines 441, 442, 443 and 444.

Lines 241, 242, 243, 244, 245, 246 and 247 – Florist, Barber/Beauty Shop, Vending Machines, Personal Purchases, Meals Sold to Guest and Employees, Activity Sales, Investment Income - Interest & Dividends Total revenue for these lines must be reported, however the total revenue may be combined and reported in column [05] Other.

Schedule E -- Schedule of Expenses

Columns [01] and [02] -- Hours Worked and Personnel The hours worked Column [01] and the personnel cost Column [02] relate to salary and wages paid for services. Hours worked include continuing education and in-service training time, but should not include vacation, sick and holiday time. Personnel hours are needed to review the reasonableness of expenses. This information should come from the general ledger, actual payroll time sheets, and/or other records. All costs for contracted services and consultants should be reported in Column [03] and not Column [02]. Column [02] should only include salaries and wages for employees. Medical Director, Other Nursing (Personnel and Consultants), Pool nursing and Dietician hours must be reported in column [01].

Column [03] -- Other Costs All costs not classified as personnel costs should be entered on appropriate expense lines of Column [03]. Costs should come from the general ledger. If unlabeled "Other" lines are used, specifically identify the nature of the item(s) reported. In general, costs that exceed \$1,000 should be separately identified. If necessary, attach a separate schedule identifying the elements that make up the amount reported on a line.

Column [24] -- Provider Adjustments Column [24] should be used to reflect any adjustments to the reported expenses including, but not limited to the following:

- Removal of non-patient related costs from Columns [02] and/or [03];
- Revenue offsets of related expenses;
- Removal of unallowable items;
- Removal of expenses associated with non-allowable vehicles;
- Allocated home office or management agreement costs;
- Transfers of costs between expense lines; and,
- Other provider adjustments.

Expenses reported on the following lines should be eliminated with negative adjustments in Column [24]: Line 392 (Advertising - All Other) and Line 398 (Contributions and Donations.) Additionally, the following are examples of unallowable items that should be eliminated with negative adjustments in Column [24]: federal income taxes; travel and entertainment to investigate investments or business opportunities; and penalties.

If amounts have been reported in both Column [02] and [03] for an expense line, a Column [24] adjustment will be presumed to pertain only to Column [02] if hours are reported unless otherwise indicated. A supplemental schedule which separately identifies each Column [24] adjustment as either a facility adjustment or a home office adjustment and includes a brief description of each adjustment should be provided.

Column [04] -- Total This column is the sum of Columns [02], [03], and [24]. Only necessary costs required for patient care are to be included in the total column.

Columns [05], [06], and [09] -- Allocations The "Allocation Base" column and the columns to the right of it are applicable only to those facilities with Other Nursing and /or Other Beds. The "Allocation Base" column should contain the numeric code of the applicable allocation basis from

Schedule F. Providers are advised that the rate setting contractor will use the allocation percentages defined by the data in Schedule F and not the actual amount entered in Columns [06] and [09] of Schedule E. Nursing personnel costs shall be allocated on the basis of nursing hours for each line. Expenses for both Other Nursing Beds and Other Beds should be combined and reported in Column [09] – Other.

Acceptable allocation bases for cost reporting purposes are those bases that are:

- Relevant -- The allocation base must have some significant relationship to the cost report line in question.
- Reliable -- The allocation base must be a faithful representation that is verifiable and unbiased.
- Consistent -- The allocation base must be determined and applied consistently from one period to the next, unless extraordinary circumstances indicate a change to a more appropriate measure. Changes in allocation basis must be approved by the OMPP or its designee prior to implementation. Requests for changes in allocation bases must be submitted to OMPP for approval at least ninety (90) days prior to the provider's reporting year end.

Lines 318, 319 and 320 -- Routine, Non-Routine Medical Supplies, and Parenteral and Enteral Nutrition (PEN) The criteria requires that both routine and non-routine medical supply items be reimbursed through the per diem rate. Proper care must be taken to ensure that the cost of these items are reported on the appropriate Line 318 (Routine Medical Supplies), 319 (Non-Routine Medical Supplies), or 320 (Parenteral and Enteral Nutrition (PEN)) respectively. Sterile water costs should be reported on Line 319 (Non-Routine Medical Supplies). All costs for legend and non-legend drugs should be reported on Line 461 – Pharmacy/Drugs.

Costs incurred for drugs or supply items covered under Medicare Part D (as discussed below) for residents who are eligible for both Medicare and Medicaid benefits (“dually-eligible”) cannot be reimbursed by Medicaid. Costs for these Medicare Part D covered drugs or supply items should therefore be removed from Schedule E with a provider adjustment to Column 24. A drug or supply item that is covered by Medicare Part D is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Medicare Modernization Act of 2003), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k)(6) of the Act). A drug covered by Medicare Part D includes prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition also includes “medical supplies associated with the injection of insulin (as defined in regulations of the Secretary).” Those medical supplies include syringes, needles, alcohol swabs, and gauze.

Line 321 -- NATCEP All costs associated with nurse aide training and competency evaluation programs (NATCEP) should be reported on Line 321 (NATCEP Costs). These costs include: (1) reimbursement made to nurses aides who personally incurred the cost of training classes, (2) wages for trainers, (3) costs associated with train-the-trainer classes, (4) training materials and supplies, and (5) costs for nurse aide testing. Providers are advised that wages for nurse aides while in training should not be reported on Line 321, but should be reported on Line 314 (Nurses Aides).

Lines 341, 342, 343 and 344 -- Laundry and Housekeeping Amounts representing the hours and cost of personnel should be reported in Columns [01] and [02] of Lines 341 (Laundry Personnel) and 342 (Housekeeping Personnel). If employees are performing duties in more than one department, the

actual hours and associated cost in each department should be reported on the appropriate line. If accumulating the actual hours and costs in each department is overly burdensome, accurate time studies that cover a two week period in each quarter of the fiscal year may be utilized if fully documented. Other non-personnel costs should be reported on Lines 343 (Laundry Supplies & Services) or 344 (Housekeeping Supplies & Services), Column [03].

Line 353 – Repairs and Maintenance Repairs and maintenance costs along with monthly maintenance fees should be reported on Line 353 (Repairs and Maintenance)

Line 357 – Other Plant Operations Plant related costs that are not plant personnel costs, utility costs, or repairs and maintenance costs and are of a nonrecurring nature should be reported on Line 357.

Lines 361, 362, 363, 364 and 365 -- Property Costs Property costs should be reported on Lines 361 (Interest on Facilities & Equipment), 362 (Depreciation - Building & Fixtures), 363 (Depreciation - Moveable Equipment), 364 (Building Lease/Rent), and 365 (Equipment Lease/Rent).

Lines 371, 373, and 374 -- Executory Costs Executory costs clearly identified and separable in lease or rental agreements should be reported on the line that is most descriptive. They should not be reported on Line 364 (Building Lease/Rent) or Line 365 (Equipment Lease/Rent), even if included in rent or lease payment. Examples of executory costs which should be reported include Lines 371 (Insurance), 373 (Real Estate Taxes) and 374 (Personal Property Taxes), respectively.

Line 377 -- Other Capital Costs Non-capitalized costs associated with minor equipment purchases that can not be directly attributed to a specific department, that should be charged to an expense according to the criteria and are related to patient care, should be reported on Line 377 (Other Capital Costs). Deferred loan fee amortization should not be reported on Line 377. The amortization expense should be reported on Line 362 (Depreciation-Building and Fixtures) with the loan fee capitalized and reported on Schedule J (Analysis of Property).

Lines 381, 382, 383, 384 -- Personnel Costs Subject to Owner, Related Party, Management Limitation Costs associated with personnel that are included in the definition at 405 IAC 1-14.6-18(a) of owners, related parties, management and general line personnel who perform management functions above the department head level who perform policy making or supervisory functions which impact the operation of the facility shall be reported in Column [02] of Lines 381 (Administrator's Salary), 382 (Co-Administrator's Salary), 383 (Owner, Related Party, Management) or 384 (Directors' Fees). Beginning July 1, 2003, Reasonable costs reported on Lines 381 (Administrator's Salary) and 382 (Co-Administrator's Salary) will be excluded from the owner, related party, management compensation limitation. Costs associated with consultants or any individual or entity that are included in the definition at 405 IAC 1-14.6-18(a) of owners, related parties, management rendering services above the department head level who perform policy making or supervisory functions which impact the operation of the facility shall be reported in Column [03] of Lines 383 (Owner, Related Party, Management) or 384 (Directors' Fees). The associated hours worked must be reported in column [01]. For full time executive and management personnel, providers may impute hours on the basis of 2,080 hours per year, if actual time records are not available. If actual time records are available, they must be used.

If the facility has entered into a management consulting agreement with a non-related party, the fees and other costs associated with the management agreement must be reported on Line 383, Column [03]. For additional reporting options, please refer to the **Chain Organizations or Management Groups** section of these instructions. If the facility has entered into a management consulting agreement with a related party, the fees and other costs associated with the management agreement must be reported at the cost to the related party on the appropriate expense lines and a Home Office Financial Report for Nursing Facilities should be submitted.

Lines 385 and 389 -- Personnel Not Subject to Owner, Related Party, Management Limitation General and administrative personnel that are not included in the definition at 405 IAC 1-14.6-18(a) shall be reported on Line 385 (Other Home Office Personnel) or Line 389 (Office and Clerical).

Line 391 -- Legal and Accounting Fees All costs associated with attorney services and accounting services associated with an audit, cost report preparation, review or compilation of financial statements should be reported on Line 391 (Legal & Accounting Fees). Question [49810] must be answered at the bottom of page six (6). If the provider incurs any legal fees or expenses related to expert witnesses, accounting fees, and other consulting fees that were incurred as the result of an administrative or judicial action or proceeding against any agency of the state or federal government, these costs should be identified by Schedule E line and column number as an attachment to the financial report. In accordance with 405 IAC 1-4.3, these costs shall not be reimbursed as reasonably related legal expenses, and should be removed by the provider in Column [24].

Lines 392 and 393 -- Advertising All advertising costs, except for help wanted advertising, should be reported on Line 392 (Advertising - All Other). Reasonable help wanted advertising is an allowable cost and should be reported on Line 393 (Advertising - Help Wanted). In accordance with 405 IAC 1-14.6-8(a), except for those advertising costs incurred in the recruitment of facility personnel necessary for compliance with facility certification requirements, advertising costs are not allowable costs and should be eliminated by the provider in Column [24] of Line 392.

Line 394 -- Travel Report on Line 394 (Travel Expenses) only the reasonable patient-related travel costs of personnel that are not owners. Owner travel that is reasonable and patient-related should be reported on line 405 (Owner's Expense).

Lines 405 and 416 -- Owner's Expenses Report on these two lines the cost of owner's expenses. Generally, the cost of discriminatory employee benefits for owners should be reported on line 416 (Owners' Benefits) and all other owner's expenses reported on Line 405 (Owners' Expense). Discriminatory employee benefits are those that tend to benefit owners proportionately more than other personnel. The entire cost of the following items that relate to owners should be reported on the applicable Line 405 or 416:

1. Travel, entertainment and continuing education
2. Automobile, aircraft, travel and transportation allowances and related costs
3. Employee benefits except benefits available to all employees on a nondiscriminatory basis
4. Cost of life insurance above the amount causing an employee to recognize taxable income
5. Employee benefits or expense reimbursements that cause an employee to recognize taxable income

Line 406 -- Consultant Fees In order for an item to be reported on this line, the consultant shall not be included in the definition of owner, related party, management or consultant at 405 IAC 1-14.6-18(a). Line 406 (Consultant Fees) is intended for reporting the cost of independent contractors that are not parties related to the facility, that provide general and administrative services related to patient care that are not normally provided in-house by employees of the facility, and where the consultant and consultant's employees lack the ability to implement. No other expense items should be reported on this line. The costs of management agreements should not be reported on Line 406, but should be reported on Line 383. A detailed listing of consultant fees must be reported on Schedule H -- Consultant Fees.

Lines 411, 412, 413, 414, 415 and 417 -- Employee Benefits Employee benefits should be reported on the line that is most descriptive of the benefit provided. Only benefits that are available to all employees on a nondiscriminatory basis should be reported on Lines 411 (Payroll Taxes), 412 (Health Insurance), 413 (Life Insurance - Not in Excess of Limits), 414 (Workers' Compensation), 415 (Qualifying Pensions) and 417 (Other Qualifying Benefits). Discriminatory benefits should be reported on Line 416 (Owners' Benefits).

Line 460 – Nursing Facility Quality Assessment Fees All Nursing Facility Quality Assessment fees incurred during the reporting period should be reported on Line 460.

Schedule F -- Allocation Bases

Schedule F applies only to those facilities with Other Nursing and /or Other Beds. Allocation bases for Other Nursing Beds and Other Beds should be combined and reported in Column [06] – Other. See the additional Schedule E instructions on allocations above. The methodology used to allocate nursing hours between nursing facility and other beds should be retained by the provider for future reference, and should be made available upon request by OMPP or its audit and rate setting contractors. The methodology used for the “Other” lines should be disclosed in an attachment to the financial report.

Schedule G -- Reconciliation of Expenses

Generally, the total costs on Schedule E (Line 498, column [02] plus column [03]) should be equal to the facility's financial statements/general ledger and tax returns. However, there may be cases where they are not equal. Any such differences should be disclosed on Schedule G by specific item and amount. If additional space is needed beyond that provided on Schedule G, include an attachment so that the nature of each reconciling item is fully disclosed.

Schedule H -- Consultant Fees

Report all contracted services, cost report preparation fees, legal fees and all consultant fees by Schedule E expense line and column number. Note that only amounts paid to unrelated parties may be reported on Schedule H. Transactions with related parties should be reported on Schedule M (Listing of Owners, Related Parties, and Management.) If the space provided is insufficient for reporting of all applicable amounts, please attach additional sheets as needed and report the totals from all sheets on Line 579 (Total).

Schedule I -- History of Bed Changes

Provide a history of bed changes in the facility from July 1, 1976 or date of acquisition, original lease, or construction, whichever is later, until the report year end. The present bed size of the facility should be the sum of entries in Column [02], which should also equal the last entry in Column [03]. If the total of Column [03] does not agree with total beds on schedule A, an explanation of the difference should be attached.

Schedule I -- Summary of Occupant Days

Census data must be accumulated from accurate census logs of the patient population. The method utilized must be sufficient to accommodate the data requirements of this schedule. Occupant days must be broken out by payor type and further broken down into reserve days and days present in the facility for Nursing Facility, Other Nursing Facility and Other residents. Resident reserve days that are eligible for IHCP payment must be reported. Resident reserve days that are not eligible for IHCP payment must not be reported.

Special Care Unit (SCU) days (Alzheimer's and dementia residents) for Medicaid residents should be reported separately on Line 185. An Alzheimer's/Dementia Special Care Unit is any identifiable part of the nursing facility, such as an entire or contiguous unit, wing, or floor where staffing patterns and resident care interventions are designed specifically for cognitively impaired residents who may or may not have a specific diagnosis of Alzheimer's disease. Medicaid days where the resident has Section I1q and Section P1n checked on their MDS assessment are reported on line 185.

Census days for residents electing either the Medicare or Medicaid hospice benefit should be reported on line 189 (Other Days).

Do not send copies of census logs with the financial report unless documentation of census data is requested by the rate setting or audit contractor.

Schedule J -- Analysis of Property

List in Column [02], on the appropriate line, the total historical cost of property at the beginning of the period. The total historical cost of property at the beginning of the period should agree with the ending balance of the previous report. Inconsistencies between the prior period ending balance and the current period beginning balance should be fully explained in an attachment. Columns [02] and [03] should only contain property additions and disposals which occurred during the reporting period. If the cost basis of any addition or disposal exceeds \$5000, the following detail should be submitted for each addition or disposal with an historical cost in excess of \$5000: date the asset was placed in service or disposed of; description and purpose of property; location; and, cost basis.

Reimbursement for vehicles is limited pursuant to 405 IAC 1-14.6-8(b). Each facility shall be allowed only one (1) patient care related vehicle. This limitation does not apply to vehicles with a gross weight in excess of six thousand (6,000) pounds. Additionally, please note that all expenses associated with non-allowable vehicles should be removed from all applicable Schedule E lines.

The requirements of 405 IAC 1-14.6-14(a) must be met. If any property is not related to patient care, it should not be reported on Schedule J. If property used for patient care is also used for non-patient care related purposes, report only the portion attributable to patient care and submit an explanation of the allocation method used to derive this portion. Property acquired from a related party must be restated at the lower of cost to the related party or the fair market value of the property.

Schedule K -- Analysis of Property Financing and Schedule L -- Analysis of Leased Property

Identify each financing or leasing component used to acquire or rent patient-related property. This can be done by reviewing the general ledger, financial statements and financing instruments such as leases, mortgage notes and other agreements. Each separate property financing, lease, or other agreement should be entered in a separate column on either Schedule K -- Analysis of Property Financing or Schedule L -- Analysis of Leased Property. Do not send the lease, loan or other agreements unless requested by OMPP or its audit or rate setting contractors. Providers should refer to the rate setting contractor's printed work papers, and whenever possible, use the same components and columns that were used in the prior year. If more components exist than there are columns, make extra copies of the form.

Enter the answers to each question in the appropriate space. Enter dates in the form MM/DD/YY (month/day/year). Most other questions can be answered with two or three words. If more space is needed, an explanation should be attached. The total of Schedule K, Line 742 (Interest Expense This Period) should agree with Schedule E, Line 361 (Interest on Facilities & Equipment). The total of Schedule L, Line 777 (Amount of Lease Payments this Period Without Executory Costs) should agree with Schedule E, Lines 364

(Building Lease/Rent) and 365 (Equipment Lease/Rent). Any exceptions to this should be explained in an attachment. If there is a property financing arrangement or lease agreement that is not entirely for patient-related property, attach a detailed explanation, including an allocation plan based on the use of the property between patient-related and non-patient related activity.

Line 766 -- Leased Property Included in Historical Cost of Patient Related Property The cost of certain leased property should be reported on Schedule J -- Analysis of Property. Property obtained through leases with related parties (Line 762 is answered Yes) should be reported on Schedule J at the lower of the cost to the related party or fair market value at the date of the lease. Any property obtained through leases with a related party should be reported on Schedule K -- Analysis of Property Financing. The cost of property acquired through capital leases with unrelated parties and any corresponding property financing should also be reported on Schedules J and K, respectively. All other leased property should be included on Schedule L.

Line 783 -- Term of Lease in Months This line refers to the initial term of the lease. Optional extension or renewal periods should not be included.

Schedule M – Listing of Owners, Related Parties, and Management

All parties that meet the definition of owners (including any individuals or organizations with a controlling interest), related parties or management personnel and contractors must be reported on Schedule M – Listing of Owners, Related Parties, and Management. Management includes general line personnel and is defined at 405 IAC 1-14.6-2(r) and related party is defined at 405 IAC 1-14.6-2(cc). List the name of the individuals and organizations for all owners, officers, stockholders and partners with five percent (5%) or more ownership interest, regardless of compensation. Additionally, include any individuals or organizations that have a controlling interest in the facility. A controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices: the ability or authority, expressed or reserved, to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved, to amend or change the by-laws, constitution, or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved, to control the sale of any or all of the assets, to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity, or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

Transactions with related party vendors must be fully disclosed on Schedule M, even if OMPP has granted the provider an exception to the related party requirements. All profits on services, facilities and supplies acquired from related organizations must be identified and removed, except where an exception has been granted by OMPP under the provisions of 405 IAC 1-14.6-11(e). Provider requests for such exceptions must be made to OMPP, or its designee, in advance of the annual effective date.

If this facility is involved with a complex ownership structure, including providers other than an individual or closely held corporation, attach an explanation including an ownership organizational chart of all ownership interests that is sufficient in scope and clarity to accomplish full disclosure.

Question [89010] must be answered. If the facility is owned by a publicly traded company, the latest annual report to stockholders and Securities and Exchange Commission (SEC) Form 10-K must be attached with the regular annual review submission.

Column [05] Type of Party – Each individual or organization reported on Schedule M should be identified by type of party: 1 (Owner, including any individuals or organizations with a controlling

interest), 2 (Related Party), 3 (Management Personnel) or 4 (Related Vendor). Multiple types may be reported.

Column [06] Percent Ownership in the Facility – Report the percentage ownership interest of all owners with five percent (5%) or more ownership interest (all lines where “1” has been circled in Column [05], (Type of Party)) in this facility. Line 889, Column [06] (Total) should equal one hundred percent (100%).

Column [07] Hours Worked – For individuals and organizations reported on Schedule M that provide patient-related services, report the hours worked associated with these services. The amounts reported in Column [07] (Hours Worked) should also be reported on the appropriate line of Schedule E, Column [01] (Hours Worked).

Column [08] Amount of Compensation – Report the compensation of all parties reported on Schedule M. Amounts reported on Schedule E, Line 381 (Administrators’ Salary), 382 (Co-Administrators’ Salary), 383 (Owner, Related Party, Management) and 384 (Directors’ Fees) should be fully disclosed on Schedule M. Compensation of owners and related parties that perform patient-related functions at or below the department head level must be reported in column [08] (Amount of Compensation), even though their compensation may be reported on Schedule E, Lines other than 381 through 384.

Columns [09] and [12] Line on Which Compensation is Reported – Report the line and column number on Schedule E on which compensation or vendor payments were reported.

Column [10] Owner’s Expenses – Report the amount of owner’s expenses for each owner. The total for Column [10] (Amount of Owner’s Expenses) should agree with the amounts reported on Schedule E, Lines 405 (Owners’ Expense) and 416 (Owners’ Benefits).

Column [11] Vendor Payments – Report the amount of payments to related party vendors or consultants. Related party vendor payments must be reported in Column [11] (Amount of Vendor Payments) even if OMPP has granted the provider an exception to the related party requirements.

Column [13] Related Party Transaction Profit Removed – Report whether the profit included in transactions between related party vendors and the provider has been removed from amounts reported on Schedules M and E. If all the profit has not been removed, report the amount of the related party profit. This should include sufficient information to identify the total related party transaction profit either on the form or in a separate attachment. If an exception to the related party rule has been granted from OMPP under the provisions of 405 IAC 1-14.6-11, indicate the date of the letter from OMPP indicating the exception approval.

Schedule N -- Balance Sheet

Report balance sheet information on Schedule N. Account balances should be reported as of the beginning and end of the cost reporting period. In most cases, the beginning of period balances should agree with the end of period balances from the prior year financial report. Any discrepancies should be fully explained in an attachment. General ledger account balances should be summarized on the lines of Schedule N that best describe the nature of the accounts. It is essential that general ledger accounts be summarized on Schedule N in a consistent manner. Amounts reported on unlabeled "Other" Lines 822, 823 and 848 should be described. Amounts reported on Lines 817 (All Loans to Owners, Officers, & Related Parties), 818 (All Assets Not Related to Patient Care), 819 (Assets Held for Investment), 846 (Property Financing Not Related to Patient Care) and 847 (All Loans from Owners, Officers, & Related Parties) should also be explained. If more space

is needed, include the required explanations in an attachment or in the cover letter. Confirm that amounts reported on Lines 818 and 819 are not reported on Schedule J and that amounts reported on Line 846 are not reported on Schedule K.

Answer question [80200] indicating the highest level of service provided by an independent accountant regarding the facility financial statements covering the report period. Copies of the financial statements should not be submitted with the Nursing Facility Financial Report, but should be made available upon request of OMPP or its rate setting and audit contractors.

Schedule O -- Reconciliation of Owners' Equity or Fund Balance

Schedule O presents the reconciliation of owners' equity or fund balance between the beginning and end of the reporting period. In most cases, the beginning of period balances Line 901 (Beginning of Period Balance) will equal the end of period balances on Line 940 (End of Period Balance) from the prior year cost report. Any discrepancies should be fully explained in an attachment. Total revenue must be disclosed on Line 905 (Revenues Per Financial Statements of Tax Return). The amount reported on Line 920 (Expenses Per Financial Statements or Tax Return) should agree with total expenses reported on Schedule E and Schedule G. If any of these amounts do not agree, a separate schedule should be submitted to fully disclose the differences. Amounts reported on unlabeled "Other" Lines 909, 910, 924, 925 and 926 should be fully described either in the space provided, in a separate schedule or in the cover letter.

Certification Statement

After adequate review of the completed form, the certification statement must be signed by a responsible person having authorization from the controlling body (board, owner, etc.) of the facility to make such representations. The certification statement submitted to the rate setting contractor must contain **original signatures**. The existence of a preparer shall be considered authorization from the facility for OMPP and its rate setting and audit contractors to discuss the annual financial report and other rate matters with the preparer. Any instructions to the contrary must be in writing from the facility.

Certification Statement by Medicaid-Enrolled Nursing Facilities that are NOT Certified to Provide Medicare Part A Skilled Nursing Services

Nursing facilities enrolled in Medicaid that are not Medicare certified must comply with the following:

- The nursing facility must certify to the OMPP that it will not request payment from Medicaid for services rendered to a dually eligible Medicaid recipient who is eligible to receive Part A nursing facility benefits from Medicare, using the Certification Statement by Medicaid-Enrolled Nursing Facilities that are NOT Certified to Provide Medicare Part A Skilled Nursing Services. As long as a nursing facility elects not to become Medicare certified, this certification must be submitted annually, along with the facility's regularly scheduled cost report submission.
- The nursing facility must maintain clinical, payment, and benefit records in sufficient detail to substantiate to the OMPP that a member for whom Medicaid payment was requested is not also entitled to or eligible for Medicare Part A nursing facility benefits. The facility must contact the Medicare fiscal intermediary to determine the availability of Medicare Part A coverage for individual residents.

- At the request of the OMPP, the nursing facility is required to make available any clinical documentation and payment and benefit information that substantiates the nursing facility's assertion that a Medicaid recipient for whom a claim has been filed is not entitled to nor eligible for Medicare Part A benefits.
- Any inappropriate billing will be considered an overpayment made by the OMPP and must be repaid by the nursing facility either through an offset from future claims or via check remitted by the nursing facility.