

**STATE OF INDIANA
FAMILY AND SOCIAL SERVICES ADMINISTRATION**

**Instructions for the Medicaid Financial Report for State Operated ICF/MR and
Psychiatric Hospitals**

GENERAL INSTRUCTIONS

These instructions are for use with the State Operated ICF/MR and Psychiatric Hospital Financial Report under provisions of the Rate Setting Criteria 405 IAC 1-17 by all State Operated ICF/MR and Psychiatric Hospital facilities that are certified as Medicaid providers by the State of Indiana Family and Social Services Administration.

Forms and Information Forms are available from the rate setting contractor, but providers are requested to reproduce copies locally whenever possible. Information may be obtained by calling 317/846-9521 or 800/877-6927.

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Annual Reports and Regular Annual Rate Review Providers must file an annual report within 90 days after their fiscal year end. This must be the same fiscal year as used for tax purposes except where the provider has made a one-time election for a different reporting year in accordance with the Criteria. Extensions of time for any filing requirement may be granted for good cause by the rate setter if requested in writing by the provider before the annual report due date or other filing due date. Providers will receive a regular annual rate review based on the annual report. Providers may also file a budget by the annual report due date, including extensions, for an interim rate review. In order to assure that the information is analyzed correctly, budgeted data must be entered on a separate form and not combined with annual report data. Providers that have not filed a budget for a regular annual rate review by the due date of their annual report will be reviewed in the absence of, and without consideration of a budget. All financial data, except per diem information, should be rounded to the nearest whole number.

Suggested Filing Format The forms are used for various filings with the rate setter under provisions of the Criteria 405 IAC 1-17. Some filings are outlined in this section.

A. Regular annual rate review. Due 90 days after the provider's report year end.

1. Cover letter explaining the filing
2. Annual report – check box [11101]

B. Interim rate review. Due 90 days after provider's report year end.

1. Cover letter explaining the filing

2. Annual report – check box [11101]
3. Expected rate effective date is the first day of the State fiscal year.
4. Budget should cover the twelve (12) month period following the expected rate effective date

C. Second interim rate review.

1. Cover letter explaining the filing
2. Rate request – historical – check box [11103]. This should contain a minimum of six months of historical data with a minimum of four of the six months subsequent to the fiscal year end of the annual financial report.
3. Rate request – budget – check box [11102]. Budget should start on the first day of the month following submission of data and end 12 months later.

D. Request for initial rate(s). Due within 30 days after notification of certification date.

1. Cover letter explaining the filing
2. Rate request – budget – check box [11102]. Twelve months of projected data beginning with the later of the certification date or the first day of establishing the new service or operation.

Refer to Criteria – Instructions Are Not Comprehensive These instructions are not intended to be comprehensive. In completing the forms, providers shall rely on the Rate Setting Criteria and other relevant rules and regulations. In addition, the results of audits or inquiry by FSSA and its audit and rate setting contractor should be considered in the preparation of the annual reports and budgets.

Cover Letter 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 to support the request. If a budget is included, the letter should describe the assumptions or basis for budget projections.

Generally Accepted Accounting Principles Required Providers are reminded that the Criteria requires adherence to generally accepted accounting principles (GAAP) unless specific Criteria language is to the contrary. One principle that has great importance in conveying information on these forms is full disclosure. In completing the forms, 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 requires accurate classification of expenses. Report all data on appropriate lines and schedules of the form. The reporting of expense amounts on inappropriate lines may tend to be misleading to the financial reader. It is particularly important to record expenses in the correct cost center and line in those cases that are subject to limitations.

Attach Explanations Instead of Altering Forms In the use of unlabeled “other” lines, specify the nature of the expense item reported. If more space is needed, attach a separate schedule. Do not make two listings on a line or change the name of a line. Column headers may not be modified nor should boxes that have been greyed out of the form be utilized when submitting data. If there are circumstances in which the form does not seem appropriate to report data in the lines available, please attach a note or schedule to explain. Lengthy or detailed workpapers involving several pages normally should not be submitted with the request, but should be retained by the provider for future reference. These should be made available when requested by FSSA and its audit and rate setting contractor.

SPECIFIC INSTRUCTIONS

Most sections and lines of the form are self-explanatory. The following items deserve extra clarification.

Provider Name and Identification Number(s)

Lines 11101, 11102, 11103 Type of Report Check the box designating whether this report is 1) an Annual Report, 2) a Rate Request-Budget, or 3) a Rate Request-Historical. An annual report and a budget should be filed for a regular annual rate review and an interim rate review.

Lines 11201 Provider Number(s) It is extremely important that the provider numbers be stated correctly. If a provider provides more than one Medicaid level of care (Mentally Impaired, ICF/MR), both Medicaid provider numbers should be reported. The incorrect use of provider numbers can result in delays of any rate increase that might be forthcoming.

Lines 20101, 20102 Period of Report Indicate the beginning and ending dates of the financial and statistical data. This is usually 12 months. In those cases involving less than 12 months, it is best to calculate the actual number of days in the period and base the required statistical and other data according to the fraction of a year involved. Budgets and regular annual rate reviews must start with the first day of the State fiscal year and end 12 months later.

Schedule A Statistical Data This section must be filled out for all beds in the facility.

Lines 141, 142 Beds Available Beds that are not certified should be reported in the “other” column. However, providers whose number of certified beds is less than the number of licensed beds may elect to use the number of licensed beds as their basis, provided that the approach would result in a reasonable reflection of cost per patient day.

Line 143 Bed Days Available In cases where the number of beds is the same at the beginning of the period as at the end of the period, total bed days available is simply the number of beds, times the number of days in the period (usually 365 or 366 if the period includes leap year, February 29th). If there was a change in the number of beds during the period, line 143 must be time weighted. Please provide the date of change between the beginning beds and the ending beds and other calculations on a separate sheet.

Lines 144, 148 Occupant Days The numbers reported must trace directly to the figures reported on Schedule M, Schedule of Occupant Days from Census Logs.

Line 153 Personnel Hours The total of all columns on line 153 should equal the total of Schedule E, line 498, column 1. If not, a reconciliation and full explanation must be provided on a separate sheet.

Schedule C Schedule of Charges If a budget is filed concurrently with the annual report, Schedule C should be left blank on the annual report. If no budget is filed, complete only columns 1 and 3 on the annual report. On a rate request – budget, complete columns 1, 2, 3 and 4.

Schedule D Schedule of Revenue Report routine service revenue on Line 211. Medicaid and private pay ancillary revenue must be reported. Income that should be offset against a related expense must also be reported. Indicate by margin notation if you have already offset related expense.

Schedule E Schedule of Expenses

Columns 1, 2 Personnel The hours worked column and the personnel cost column relate to salary, wages and contractual amounts paid for services customarily performed by in-house employees. Hours worked includes continuing education and in service training time. Personnel hours are required to review the reasonableness of expenses. This information should come from the general ledger, actual payroll timesheets, contractual invoice billings and other records. If an entry is made either in column 1 or 2, there should be an entry in the other column.

Column 3 Other Expense All expenses not classified as personnel costs should be entered on appropriate expense lines of column 3. Expense amounts should come from the general ledger. If unlabeled “other” lines are used, specifically identify the nature of the item reported. In general, expense amounts over \$1,000 should be separately identified. If necessary, attach a schedule identifying the elements going into the amount being reported on a line.

Column 24 Provider Adjustments This column facilitates providers removing costs from amounts reported (columns 2 and 3) that are not patient related expenses. The column can be used to offset certain revenue items against related

expenses. Negative adjustments should be shown in brackets. For example, to remove \$149 of cost from a line, write “<\$149>” in column 24. If an adjustment is made on a line where there are amounts in both columns 2 and 3, it will be assumed that the adjustment pertains only to column 3, other costs; otherwise, if only personnel costs are reported, it will be assumed that the adjustment pertains to column 2. The following lines should be eliminated (reduced to zero) with a negative adjustment in the provider adjustment columns: Line 392 Advertising – Promotional, Line 398 Contributions and Donations. The following are examples of unallowable items: travel and entertainment to investigate investment or business opportunities and federal income taxes. These costs should be eliminated.

Column 4 Total Patient Related Expense This column is the sum of columns 2, 3 and 24. Only expenses related to patient care should be included.

Columns 5, 8, 10 Allocations The “Allocation Base” column and the columns to the right of it are applicable only to those facilities with more than one certification, such as facilities that are not entirely certified. The “Allocation Base” column should contain the numeric code of the applicable allocation basis in Schedule F. Be aware that the rate setter will use the method defined by the code number referenced to the data in Schedule F and not the actual amount entered in the allocation columns.

Consistency is a requirement of GAAP. Allocation methods must not change from year to year without prior approval from the rate setter. Changes will not be approved unless a more desirable method is proposed and the new method would not result in an unreasonable cost finding. The same method of allocation must be used on the budget as is used on the annual report. Nursing personnel shall be allocated on the basis of nursing hours for each line.

Medicare Part D Drug Costs 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.

Lines 341, 342, 343, 344 Laundry and Housekeeping Amounts representing the hours and cost of personnel should be reported in columns 1 and 2 of lines 341 and 342 regardless of whether those services are performed by employees or through contractual arrangements. If contractual services are used, the provider should ask the contractor for documentation of personnel hours and a break down between personnel cost and other expenses. Other expenses should be reported on lines 343 or 344, column 3.

Lines 361, 362, 363, 364, 365 Property Costs It is necessary to report interest on capital financing on Line 361; Depreciation costs should be calculated on a straight line basis using the following depreciable lives:

Property	Depreciable Life
Land Improvements	20 years
Buildings and building components	40 years
Building improvements	20 years
Movable equipment	10 years
Vehicles	4 years
Software	3 years

Lease costs for buildings and equipment should be reported on Lines 364 and 365, respectively.

Lines 371, 372, 373, 374, 377 Executory Costs Executory costs arising from lease or rent 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 lease/rent payment. Examples of executory costs include insurance, line 371; repairs and maintenance, line 372, and personal property taxes, line 374.

Lines 381, 382, 383 Personnel Costs Subject to Owner, Related Party, Management Limitation General and administrative personnel costs that are included in the owner, related party or management definition at 405 IAC 1-17 shall be reported on these lines. For full time executive and management personnel, providers may utilize 2080 hours per year less up to 10% for vacation and other lost time, if actual time records are not available. If actually time records are available, they must be used.

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 1-17 shall be reported on these lines. Services obtained through contractual arrangements which are customarily performed by in-house employees must be reported in columns 1 and 2. The provider should ask the contractor for personnel hours.

Lines 392 and 393 Advertising Promotional advertising is not an allowable cost but should be reported on line 392 and eliminated in the provider adjustment column. Reasonable advertising expense for help wanted is allowable. Allowable advertising should be reported on line 393.

Line 394 Travel Report on line 394 only the reasonable patient related travel costs of personnel that are not owners. Owner travel is either not allowable or is reported on line 405, Owner's Expenses.

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 or management at 405 IAC 1-17. The line is intended for reporting the cost of independent contractors not related to anyone associated with the facility that are providing general and administrative services related to patient care that are not normally provided in house by employees of the facility and where the consultant or consultant's employer lacks the power to implement. No other expense items should be reported on this line. A detailed listing must be reported in Schedule H. Amounts under \$5,000 may be combined so the schedule will total to the amount on line 406.

Schedule F Allocation Base This applies only to those facilities that are not entirely certified. See the instructions on allocations above.

Schedule G Reconciliation of Expenses Generally the total expenses on Schedule E (line 498 col. 2 plus col. 3) should be equal to expenses per books. However, there can be cases where they are not equal. Reveal such differences on Schedule G by specific item and amount. Rate request – budget shall not complete this schedule.

Schedule H Management Consultation Fees Report such fees by amount and Schedule E expense line number on this schedule. Note that only fees to unrelated parties may be reported on line 406. Transactions with related organizations are reported on Schedule N.

Schedule I -- Listing of Related Parties and Management

All parties with which the provider has conducted transactions during the reporting period that meet the definition of owners, related parties or management personnel and contractors must be reported on Schedule I -- Listing of Related Parties and Management.

Transactions with related party vendors must be fully disclosed on Schedule I. All profits on services, facilities and supplies acquired from related organizations must be identified and removed.

Column [05] Type of Party -- Each individual or organization reported on Schedule I should be identified by type of party: 1 (Related Party), 2 (Management Personnel) or 3 (Related Vendor). Multiple types may be reported.

Column [06] Hours Worked -- For individuals and organizations reported on Schedule I that provide patient-related services, report the hours worked associated with these services. The amounts reported in Column [06] (Hours Worked) should also be reported on the appropriate line of Schedule E, Column [01] (Hours Worked).

Column [07] Amount of Compensation -- Report the compensation of all parties reported on Schedule I. Amounts reported on Schedule E, Lines 381 (Administrators' Salary), 382 (Co-Administrators' Salary), and 383 (Owner, Related Party, Management) should be fully disclosed on Schedule I. Compensation of related parties that perform patient-related functions at or below the department head level and must be reported in column [07] (Amount of Compensation), even though their compensation may be reported on Schedule E, Lines other than 381 through 383.

Columns [08] and [10] Line on Which Compensation is Reported -- Report the line and column number on Schedule E on which the compensation or vendor payments were reported.

Column [09] Vendor Payments -- Report the amount of payments to related party vendors or consultants. Related party vendor payments must be reported in Column [09] (Amount of Vendor Payments) even if OMPP has granted the provider an exception to the related party requirements.

Column [11] 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 I 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.

Schedule J Analysis of Property On an annual report, the historical cost at the beginning of period should be equal to the ending balance on the previous annual report. On a rate request – budget the historical cost at the beginning of period should be equal to the ending balance on the latest annual report. The additions and disposals columns should reflect anticipated changes for the 12 month period starting with the annual report year end and ending with the last day of the 12 month budget report period.

Schedule K and L Financing and Leasing 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 component (each separate mortgage, property loan, lease) should be entered in a separate column in either Schedule K or L. Whenever possible, use the same components and columns as were used in the prior year. Refer to the rate setters printout worksheets. If more components exist than there are columns, use extra pages of the form. Enter the answers to each question in the appropriate space. Many items are dollar amounts or dates. Enter dates in the form MMDDYY. Most other questions can be answered with two or three words. If more space is needed, attach an explanation.

Schedule M Summary of Occupant Days from Census Logs Census data must come from accurate census logs of patient population. The method utilized must be sufficient to accommodate the data requirements of this schedule. Do not send copies of census logs with the annual report or rate request unless documentation of census data is requested by the rate setter.

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 existence of a preparer shall be considered authorization from the facility for the rate setter and/or FSSA to discuss the annual report and other rate matters with the preparer. Any instructions to the contrary must be in writing from the facility.