Introduction to Presenters

Mariah Starks- Mariah is a Learning and Development Specialist with Myers and Stauffer LC based in the Kansas City office.

Taryn Gulkewicz - Taryn is a Healthcare Reimbursement Analyst with the Department of Medical Assistance Services (DMAS). She completes the rate-setting process for a variety of fee-for-service providers, including PRTFs and ARTS providers.

Les Wingfield - Les is a Manager with Myers and Stauffer LC with 24 years of experience in healthcare accounting. He currently co-manages the review of Virginia Medicaid cost reports for Nursing Facilities and has also worked on PRTF and ARTS cost report reviews in recent years.

Ellen Han - Ellen is a Manager with Myers and Stauffer LC with 15 years of experience in healthcare accounting. She currently co-manages the review of Virginia Medicaid cost reports for Nursing Facilities and has also worked on PRTF and ARTS cost report reviews in recent years.

OBJECTIVES

To share information on the following:

- Budget Language for submitting cost report
- Completing the cost report
- Documentation needed when submitting the cost report
- Cost report review process/request for additional data
- Submitting the cost report

Budget Language

2022 Special Session I Virginia Acts of Assembly

X.1. Effective July 1, 2021, the Department of Medical Assistance Services shall amend the State Plan for Medical Assistance to revise per diem rates paid to psychiatric residential treatment facilities (PRTF) using the provider's audited cost per day from the facility's cost report for provider fiscal years ending in state fiscal year 2018. New Virginia-based residential psychiatric facilities must submit proforma cost report data, which will be used to set the initial per diem rate for up to two years. After this period, the department shall establish a per diem rate based on an audited cost report for a 12-month period within the first two years of operation. Providers that do not submit cost reports shall be paid at 75% of the established rate ceiling. If necessary to enroll out-of-state providers for network adequacy, the department shall negotiate rates. If there is sufficient utilization, the department may require out-of-state providers to submit a cost report to establish a per diem rate. In-state and out-of-state provider per diem rates shall be subject to a ceiling based on the statewide weighted average cost per day from fiscal year 2018 cost reports. The department shall have the authority to implement these changes effective July 1, 2021, and prior to the completion of any regulatory process undertaken in order to effect such change.

2. The Department of Medical Assistance Services shall have the authority to establish rebasing of PRTF rates every three years. The first rebasing of rates shall take effect July 1, 2023. All PRTF and Addiction and Rehabilitation Treatment Services (ARTS) providers who offer qualifying services under 12VAC30-70-418(C) shall be required to submit cost reports as a part of rebasing. Out of state providers with more than 1,500 paid days for Virginia Medicaid members in the most recently completed state fiscal year shall also be required to submit a cost report. A rate ceiling shall be established based on a statewide weighted average cost per day. Rate ceilings shall be established independently for PRTFs and participating ARTS residential services. The department shall have the authority to implement these changes effective July 1, 2022 and prior to the completion of any regulatory process to effect such change.

Cost Report Schedule A

RTF Form 608 V 3 will be used for this rate setting process

Schedule A – Statistics

- Record name, physical address of facility, NPI, fiscal period
- Check type of facility certified
- Inpatient Statistical Data:
  - Complete lines 1-8 as indicated – Line 3, total beds available, should be # of beds times number days in year/period.
- Line 4 Total inpatient days – support must be provided
- Line 9 – report number of FTEs as indicated
- Line 10 – report most prevalent semi-private room rate in effect at the fiscal year end
- Lines 11-13 – report information as indicated

RESIDENTIAL TREATMENT FACILITY (RTF) STATISTICAL AND OTHER DATA

NAME OF RESIDENTIAL TREATMENT FACILITY: ____________________

ADDRESS: ____________________

TYPE OF CONTROL

VOLUNTARY NONPROFIT:
1 ____ CHURCH
2 ____ OTHER: PRIVATE

3 ____ PROPRIETARY:
____ INDIVIDUAL
____ PARTNERSHIP
____ CORPORATION
____ OTHER

GOVERNMENT (NON-FEDERAL):
4 ____ STATE
5 ____ COUNTY
6 ____ CITY
7 ____ CITY-COUNTY
8 ____ HOSPITAL DISTRICT
9 ____ OTHER

TYPE OF FACILITY CERTIFIED

1 ____ ENTIRELY CERTIFIED RESIDENTIAL TREATMENT FACILIT
2 ____ RESIDENTIAL TREATMENT FACILITY THAT PROVIDES A LOWER LEVEL OF CARE
3 ____ OTHER:

PERIOD COVERED BY STATEMENT FROM: ____________ TO: ____________ NPI ____________

STATISTICAL DATA

COMPLETE COLS 1 AND 2 FOR TYPE OF FACILITY CHECKED

INPATIENT STATISTICS - ALL PATIENTS

		1, 2, & 3 ABOVE DISTINCT PART OF FACILITY 1	TOTAL FACILITY 2
1	BEDS AVAILABLE AT BEGINNING OF PERIOD		
2	BEDS AVAILABLE AT END OF PERIOD		
3	TOTAL BED DAYS AVAILABLE		
4	TOTAL INPATIENT DAYS		
5	PERCENTAGE OF OCCUPANCY (LINE 4 / LINE 3)		#DIV/0!
6	DISCHARGES, INCLUDING DEATHS		
7	AVERAGE LENGTH OF STAY - INPATIENTS		
8	NUMBER OF ADMISSIONS		

Total inpatient days has to be supported with census or other internal data from the provider.

OTHER STATISTICS

		1ST QTR	2ND QTR	3RD QTR	4TH QTR
9	TOTAL NUMBER OF EMPLOYEES ON PAYROLL (FIRST WEEK OF QUARTER)				
A	AVERAGE NUMBER OF FULL TIME EQUIVALENT ON PAYROLL (FIRST WEEK OF QUARTER)				
B	NUMBER OF REGISTERED NURSES (FTE)				
C	NUMBER OF LPNs (FTE)				
D	NUMBER OF MENTAL HEALTH PROFESSIONALS (FTE)				
E	NUMBER OF THERAPISTS (FTE)				
F	NUMBER OF AIDES AND OTHER PERSONNEL ASSISTING IN PATIENT CARE (FTE)				

10 MOST PREVALENT SEMI-PRIVATE ROOM RATE IN EFFECT AT FISCAL YEAR END ____________

QUESTIONNAIRE

11 HOW WAS DEPRECIATION INCLUDED IN COST STATEMENT CALCULATED?

1 ____ STRAIGHT LINE
2 ____ DECLINING BALANCE
3 ____ SUM-OF-YEARS DIGITS
4 ____ OTHER (SPECIFY)

12 IS DEPRECIATION FUNDED? ____ YES ____ NO BALANCE IN FUND AT END OF PERIOD: ____________
IF YES: WHAT BASIS ____________

13 WERE THERE ANY GAINS OR LOSSES ON DISPOSALS OF CAPITAL ASSETS DURING PERIOD?
____ YES ____ NO
INCLUDED IN EXPENSES? ____ YES ____ NO
WHERE? ____________

Cost Report Schedule B

Classification of Adjustments and Expenses

- Report salaries and expenses as listed in the trial balance/general ledger under columns 1 and 2. The amounts under the two columns must be traced to a grouping schedule or an analysis prepared by the provider.

NOTE: Administration and General, column 2 will come from expenses listed on Schedule B-2.

- Column 3 is the total of columns 1 and 2.
- Column 4 will include the total adjustments (increases/decreases) made to each cost center line as indicated on Schedule B-1.
- Column 5 is the facility's adjusted expenses.
- Non-Allowable costs on lines 25-30 will be deducted on Sch. F – amounts should be entered as positive numbers. These are costs associated with the Facility, but not included in the rate.

SCHEDULE B

PROVIDER NAME: ______________________

NPI: __________

FYE: __________

CLASSIFICATION AND ADJUSTMENT OF EXPENSES (Omit Cents)

ACCOUNT	DIRECT EXPENSES PER BOOKS			ADJUSTMENTS TO EXPENSES (SCH B-1)	ADJUSTED EXPENSES (COL 3 + 4)	
	SALARIES 1	OTHER 2	TOTAL (1 + 2) 3	4	5	
ADMINISTRATIVE AND GENERAL						1
INTEREST EXPENSE						2
DEPRECIATION-BUILDINGS, ETC.						3
DEPRECIATION-MOVABLE EQUIPMENT						4
DIETARY - RAW FOOD						5
DIETARY - OTHER EXPENSE						6
HOUSEKEEPING						7
LAUNDRY AND LINEN						8
OPERATION OF PLANT - UTILITIES						9
MAINTENANCE OF PLANT/REPAIRS						10
NURSING SERVICE						11
MEDICAL SUPPLIES AND EXPENSE						12
MEDICAL RECORDS						13
SOCIAL SERVICES						14
OCCUPATIONAL THERAPY						15
SPEECH THERAPY						16
PHYSICAL THERAPY						17
OTHER THERAPY						18
PATIENT ACTIVITIES PROGRAM						19
						20
						21
						22
TOTAL ALLOWABLE RTF FACILITY COSTS						23
NON-ALLOWED RTF COSTS:						24
EDUCATION/SCHOOL						25
PHARMACY/DRUGS						26
PROFESSIONAL FEES (PHYSICIANS)						27
						28
						29
						30
TOTAL EXPENSES						31

FORWARD TO SCHEDULE F, LINE 4

Depreciation expenses need to be supported by depreciation schedule.

Amounts reported under salaries and other expenses should be traced to a grouping schedule or a provider's analysis to show these amounts are supported.

RTF - Form 608 V 2

Cost Report Schedule B-1

Adjustment/Reclass to Expenses

- This schedule is provided to record adjustments (decreases) for non-reimbursable costs. Examples: marketing, contributions, offset of miscellaneous income. (Marketing expenses related to business development are not allowable)
- This schedule is provided to record adjustments (increases) for allowable expenses not recorded in the trial balance. Examples: overhead costs, allocations from related parties (Allocation schedule from related parties must be provided as supporting document).
- The total adjustment amounts should trace to Column 4 of Schedule B.
- Do not change/overwrite/mark out a standard description line in the Description column. Indicate the basis for the adjustment (A=Expense amount; B=Offset of income amounts).
- Record the description of adjustment, basis, amount of adjustment, name of cost center and the line number of the cost center.
- Detailed worksheets for adjustments including computations and account numbers should be furnished with the cost report.

SCHEDULE B-1

PROVIDER NAME: ______________________

NPI: ______________

FYE: ______________

ADJUSTMENT/RECLASS TO EXPENSES (Omit Cents)

	DESCRIPTION	BASIS FOR ADJUSTMENT*	(1) AMOUNT INCREASE AND (DECREASES)	(2) SCHEDULE B EXPENSE CLASSIFICATION	(3) COL 4 LINE #
1	Telephone Service (Pay Stations Excluded)			Admin & General	1
2	Radio and Television Service			Admin & General	1
3	Vending Machines Commission			Operation of Plant	9
4	Employee and Guest Meals			Dietary - Raw Food	5
5	Sale of Scrap, Waste, etc.			Maintenance of Plant	10
6	Rental of Quarters to Employees and Others			Admin & General	1
7	Rental of Facility Space				
8	Rebates and Refunds of Expenses				
9	Trade, Quantity, Time and Other Discounts on Purchases				
10	Interest on Unrestricted Funds				
11	Grants, Gifts, and Income designated by the Donor for Specific Expenses				
12	Bad Debts			Admin & General	1
13	Fund Raising Expenses				
14	Depreciation			Depreciation-Buildings	3
15	Depreciation			Depreciation-Movable Equip	4
16	Pharmacy			Med Supplies & Exp	12
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					
53					
54	TOTAL				

* Basis for Adjustment: A = Cost/Expense (if known) B = Amount Received if cost/expense is not known (This would be an offset of income)

Cost Report Schedule – B-2

Analysis of Administrative and General-Other

- This schedule provides an analysis/breakdown of the Administrative and General (A&G) Costs – Other. All the costs reported on schedule B-2 need to be supported by documentation, which can be the working trial balance or grouping schedule.
- The total A&G costs should trace to Schedule B, line 1, column 2 (There is a formula in that cell on Schedule B to pick up the total).

SCHEDULE B-2

PROVIDER NAME: ____________________

PROVIDER NUMBER: ____________

FYE: ____________

ANALYSIS OF ADMINISTRATIVE AND GENERAL - OTHER (Omit Cents)

	EXPENSE CLASSIFICATION		AMOUNT
1	Advertising		
2	Telephone		
3	Dues & Subscriptions		
4	Equipment Rental		
5	Office Supplies		
6	Printing & Postage		
7	Other (Specify)		
8	Purchased Services		
9	Travel		
10	Auto		
11	Public Relations		
12	Taxes & Licenses		
13	Insurance		
14	Payroll Taxes / Employee Benefits		
15	Consultants (Specify)		
a			
b			
c			
d			
16	Non-Allowables: (Specify & post individually to Schedule B-1)		
a	BAD DEBTS		
b			
c			
d			
	Total Administrative & General Cost (To Schedule B, Line 1, Col 2)		

Cost Report Schedule C

Statement of Services from Related Organization

- Complete this schedule if the RTF has incurred costs which are the result of transactions with a related organization.
- Related organizations are defined in Chapter 10 of the CMS PUB 15-1: 1000.
- If there are costs from related organizations, complete sections B and/or C.

Allocations

- *Per CMS Pub. 15-1: 2150.3 (C), "The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any non-provider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs."*

- In all instances where costs are being allocated, providers must use an appropriate, equitable method for allocations. Providers may elect the allocation method they deem most appropriate for their facility and the type of cost being allocated; but documentation must be provided to support the allocation statistic, and justification for the statistic used may be requested.

SCHEDULE C

PROVIDER NAME: ____________________

NPI: ________

FYE: ________

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

A IN THE AMOUNT OF COSTS TO BE REIMBURSED BY THE HEALTH INSURANCE PROGRAM, ARE ANY COSTS INCLUDED WHICH ARE A RESULT OF TRANSACTIONS WITH A RELATED ORGANIZATION AS DEFINED IN CHAPTER 10 OF CMS PUB. 15-1?

____ YES ____ NO (IF "YES", COMPLETE PART B, AND SUBMIT SCHEDULE ITEMIZING TOTAL EXPENSES AND BASIS OF ALLOCATION)

B COSTS INCURRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS (Omit Cents)

FORM NO	LINE NO	ITEM	AMOUNT
B			
B-2			
B-2			

C NAME AND PERCENT OF OWNERSHIP IN THE RELATED ORGANIZATIONS

NAME OF OWNER	NAME OF RELATED ORGANIZATION	% OWNERSHIP

Definition of Related Organizations per CMS PUB 15-1:1002.1:

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.

Cost Report Schedules D and E

Schedule D Statement of Compensation of Owners

- Compensation as used in this schedule is defined in Chapter 9 of the CMS Pub. 15-1.
- Complete information as indicated – for sole proprietor, partners or corporate officers. Make sure to list the title and function of the owner, be specific when the owner is also the administrator.
- If no information is needed, please include "N/A" on first line of schedule.

Schedule E Statement of Compensation Paid to Administrators (other than owners)

- Compensation used in this schedule is defined in *12VAC30-90-52(B)* which states *"Administrator Compensation shall mean remuneration paid regardless of the form in which it is paid…..".*
- Complete information as indicated.
- If no information is needed, please include "N/A" on first line.

SCHEDULE D

PROVIDER NAME: ______________________

NPI: ____________

FYE: ____________

STATEMENT OF COMPENSATION OF OWNERS (Omit Cents)

		SOLE PROPRIETOR	PARTNERS		CORPORATE OFFICERS		
NAME	TITLE & FUNCTION	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	% SHARE OPERATING PROFIT OR (LOSS)	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	% OF PROVIDER'S STOCK OWNED	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	COMPLETE INCLUSIVE ALLOWABLE COSTS FOR PERIOD
(1)	(2)	(3)	(4a)	(4b)	(5a)	(5b)	(6)

SCHEDULE E

PROVIDER NAME: ______________________

NPI: ______________

FYE: ______________

STATEMENT OF COMPENSATION PAID TO ADMINISTRATORS
AND/OR ASSISTANT ADMINISTRATORS (OTHER THAN OWNERS) [Omit Cents]

NAME	TITLE & FUNCTION	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	COMPENSATION FOR THE PERIOD
	TOTAL:	0%	

Cost Report Schedule F

Calculation of Residential Treatment Facility Cost Per Day

- This schedule is provided for calculating the Medicaid Program cost per day as well as the certification statement to be signed by an official of the Facility.

- To be valid, a completed cost report MUST be signed in ink and dated by an authorized Officer/Administrator of the facility.

- All fields on the schedule are formulas except Line 2 – Total RTF Medicaid Program Days. A copy of support for Total Medicaid days is required.

SCHEDULE F

PROVIDER NAME: ______________________________

NPI: __________

FYE: __________

CALCULATION OF RESIDENTIAL TREATMENT FACILITY COST PER DAY (Omit Cents)
FOR THE COST REPORTING YEAR

1	TOTAL PATIENT DAYS (FROM RTF-608, SCHEDULE A, COLUMN 1, LINE 4)	
2	TOTAL RTF MEDICAID PROGRAM PATIENT DAYS (FROM PROVIDER'S RECORDS)	
3	PERCENT OF RTF PROGRAM PATIENT DAYS TO TOTAL DAYS (LINE 2 / LINE 1)	0.00%
4	TOTAL RTF FACILITY COSTS (FROM RTF-608, SCHEDULE B, LINE 31)	
5	LESS NON-ALLOWABLE RTF FACILITY COSTS (SCHEDULE B - SUM OF LINES 24 - 30)	
6	LESS PLANT COSTS (SCHEDULE B - SUM OF LINES 2 - 4)	
7	OPERATING COSTS (LINE 4 MINUS LIINES 5 AND 6)	
8	PROGRAM OPERATING COST (LINE 3 x LINE 7)	
9	PROGRAM OPERATING COST PER DAY (LINE 8 / LINE 2)	#DIV/0!
10	PROGRAM PLANT COST (LINE 3 x LINE 6)	
11	PROGRAM PLANT COST PER DAY (LINE 10 / LINE 2)	#DIV/0!
11	PROGRAM RTF FACILITY COST PER DAY (LINE 8 + LINE 10)	#DIV/0!

INTENTIONAL MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Statements of Financial Position, Activities and Cash Flows prepared by:
______________________________ for the cost report period beginning __________ and ending __________ , and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed)

____
Officer or Administrator of Provider

____
Title

____
Date

Documentation Needed for Cost Report Review

- Completed cost reporting form RTF 608V3 provided by DMAS in pdf and Excel format.

  The Pdf copy needs certification with signature, title and date manually signed.
- The provider's trial balance/general ledger.
- Grouping schedule that shows amounts from the trial balance/general ledger that agree to amounts reported on the cost report (Schedule B, B-1, B-2).
- Documentation for total patient days and Medicaid patient days (NO PHI)
- Depreciation schedule or summary with depreciation expense that agrees to amounts reported in the cost report.
- Allocation schedules of costs from related organizations (Schedule C)
- Home office cost report, if applicable.

Review Process of the Cost Report

- Analyst will review cost report and documentation submitted. Additional information may be requested via email to complete review. Please respond fully and promptly to facilitate the review process.
- Be sure the contact person and email address are correct if it is changed during the review process.
- Once the cost report has had management review, you will receive an email containing a revised report with adjustments. Please respond with agreement to adjustments or with further documentation/questions.
- Request for signed Management Representation Letter will be sent. Please print to your company's letterhead; should be signed and dated by the Administrator, Officer or someone legally allowed to sign for the Provider.

Submission of the Cost Report/Documentation

The completed cost report and documentation should be submitted to the DMAS Cost Settlement and Auditing contractor, Myers and Stauffer LC by email to ARTSproforma@mslc.com.

- DO NOT SEND PHI! If a secure method is needed, please send request to ARTSproforma@mslc.com and we will request access to our MSLC FTP website.

Contacts for Cost Report:

- Andrea Crump – acrump@mslc.com
- Ellen Han – ehan@mslc.com
- Ayana Washington – awashington@mslc.com
- Les Wingfield – lwingfield@mslc.com