State of Montana
Department of Public Health and Human Services
Senior and Long Term Care Division

Instructions for Completing the Montana Medicaid Cost Report for Nursing Facilities

PURPOSE/INTRODUCTION

The purpose of this report is to obtain the resident-related costs incurred by nursing facilities in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The Montana Medicaid Cost Report for Nursing Facilities, as revised for 1996 and subsequent years, consists of worksheets from the Federal Form CMS-2540 or CMS-2552 and the Montana Medicaid Questionnaires and Forms. Also, the provider must include a copy of their complete trial balance and depreciation schedule as of the end of the cost report period.

SUBMITTAL INSTRUCTIONS

A. To request forms or for assistance completing the forms, contact Senior and Long Term Care (SLTC) Division at (406) 444-4129.

B. Send one copy of the completed Montana Medicaid Cost Report for the reporting period to the following address:

ATTENTION: REVIEW AUDITOR
SENIOR AND LONG TERM CARE DIVISION
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
P.O. BOX 4210
HELENA, MT 59604

General

A. Complete the worksheets and forms accurately and legibly. Cost Reports prepared in pencil **will not be accepted** by the Department. Please prepare the cost report in pen or some other printed format.

B. All totals must be rounded to the nearest dollar.

C. **DO NOT** add lines to the forms. Use ‘OTHER’ lines for resident-related expenses not designated on the expense worksheets. Attach a schedule if necessary.

D. **DO NOT** cross out or re-title lines on the worksheets. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation.

E. Enter provider (CONDUENT) Medicaid ID number in the appropriate blank space for each applicable worksheet.

F. Providers are reminded that Generally Accepted Accounting Principles (GAAP) should be used in reporting financial data. The accrual method of accounting is required for cost reporting for all providers except for governmental facilities. For the accrual method of accounting, revenues are reported in the period when **earned**, not when received. Expenses are reported when **incurred**, not when paid. Allowable costs must be in accordance with the Administrative Rules of Montana (ARM) Section 37.40.345.

G. Estimates of revenues and expenses are not acceptable.

H. Cost reports must be filed within 150 days after the end of the provider's fiscal year, in accordance with Section 37.40.346 (4) (a) of the Administrative Rules of Montana (ARM). Providers will be notified of the filing date when the cost report packets are sent out late due to revisions or other circumstances.

I. ARM Section 37.40.346 (4) (b) specifies the provisions for reporting allowable costs and states:

> (4) All providers must report allowable costs based upon the provider's fiscal year and using the financial and statistical report forms designated and/or provided by the department. Reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction.
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> (b) The report forms required by the department include certain Medicare cost report forms and related instructions, including but not limited to certain portions of the most recent version of the CMS-2540 or CMS-2552 cost report forms, as more specifically identified in the department's cost report instructions. The department also requires providers to complete and submit certain Medicaid forms, including but not limited to the most recent version of the Medicaid expense statement, form DPHHS-MA-008A.
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> (i) In preparing worksheet A on the CMS-2540 or CMS-2552 cost report form, providers must report costs in the worksheet A category that corresponds to the category in which the cost is reportable on the Medicaid expense statement, as designated in the department's cost reporting instructions.
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> (ii) For purposes of the Medicaid cost report required under this rule, all Medicare and Medicaid cost report forms must be prepared in accordance with applicable cost report instructions. Medicare cost report instructions shall apply to Medicare cost report forms to the extent consistent with Medicaid requirements, but the Medicaid requirements specified in these rules and the department's Medicaid cost reporting instructions shall control in the event of a conflict with Medicare instructions.

J. ARM Section 37.40.346 (4) (c), (d), and (e) specifies the provisions for an extension of the filing deadline and the handling of late and incomplete cost reports. The provisions are, in summary, that one 30-day extension of time to file the cost report may be requested in a letter prior to the filing deadline. The request letter must contain an explanation of the reason for the request. If a provider does not file the cost report by the due date, including extension, or files an incomplete cost report, an amount equal to 10 percent of the provider's Medicaid reimbursement for the following month shall be withheld by the Department. The withholding percentage increases to 20 percent for the second delinquent month and 100 percent for all subsequent months. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

K. Extensions to file the cost report will only be granted in **extraordinary** circumstances. The following types of situations will **not** be considered extraordinary:

1. the facilities contracted accountant is too busy doing other work;

2. the facility is contracting with a different accountant this year or there has been a change in the facilities staff person responsible for the preparation of the cost report;

3. the facilities staff "does not have the time".

Prior approval of extensions **must** be obtained from the Department well in advance of the filing deadline. Requests for an extension **must** be in writing.

The cost report preparer should review the cost reporting requirements, particularly as they pertain to Medicaid cost reporting requirements and guidelines. (The Administrative Rules of Montana (ARM) 37.40.345 contains the section that applies to determining allowable costs.)

COST REPORT INSTRUCTIONS
CMS-2540-96 AND
MEDICAID QUESTIONNAIRES

A. FORM DPHHS MA-001 MEDICAID COST REPORT WORKSHEET CHECKLIST

Use this form as a checklist to assure that all the required cost reporting forms are included in the cost report packet. Enter the Provider Name; Period Covered; and Provider Medicaid ID Number.

B. FORM DPHHS MA-008E CERTIFICATION

Enter the Provider Name, Period Covered, and Provider Medicaid ID Number.

ARM 37.40.346 (4) (f) requires that cost reports shall be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider or an authorized officer of a corporate provider. The cost report certification should be submitted with an **original signature** rather than a copy of the signature.

Please identify the cost report preparer. This will help address any questions that could occur when the cost report is filed with the Department.

C. FORM DPHHS MA-008A EXPENSE STATEMENT

The purpose of these forms is to provide a standard chart of accounts for cost reporting to enable the Department to analyze comparable costs among all providers. The forms have been designed to facilitate the preparation of worksheet A by serving as a summary of the provider's trial balance expenses grouped by cost center/accounts into the worksheet A cost center format. Providers must report costs in the worksheet A category that corresponds to the category in which the cost is reported on the Medicaid expense statement.

DIRECTIONS:

Transfer the amount from each expense account on the provider's trial balance to the Amount column for the most appropriate line on the Expense Statement (pages 1–7). For those lines composed of two or more provider expense accounts, enter only the total amount of all accounts combined on that line. Enter the applicable general ledger account numbers or trial balance index numbers in the adjoining Provider Account Numbers column. The Provider Account Numbers column will enable the Department to reconcile reported amounts to the specific expense accounts on the copy of the provider's trial balance which is required to be submitted with the cost report. A supplementary schedule may be attached to this form to detail the provider's accounts that total the line item identified on this form.

Please note that all expense accounts, including the Ancillary Service and Non-Reimbursable accounts, should be entered on this form and carried over to worksheet A. It is not appropriate to preclude the step-down of indirect costs to these cost centers by entering the expense amounts on worksheet G-2 instead of worksheet A.

Finally, all amounts should be totaled on page 7 of the Expense Statement. This total must agree to worksheet A, column 3, last line.

Total Annual Hours Paid, column 1 – Enter the total hours paid to the employees on only the nursing facility/nursing service salary lines on page 6 of 7 for the reporting period. Employees shall be reported on the appropriate salary line for their position classification.

Amount Per Trial Balance, column 2 – Report the expenses reflected in the accounting records under the appropriate cost center (e.g., Administration, Plant, Dietary).

Provider Account Number, column 3 – Enter the applicable general ledger account number(s) or trial balance index number(s).

Worksheet A (Line & Column), column 4 – Enter the applicable line and column to identify the location of each amount after transfer to worksheet A.

EXPENSE LINES

GENERAL: All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. **Do not cross out or use a line designated for a particular type of expense for some other type of expense.**

NOTE: COMBINED FACILITIES (HOSPITAL/NURSING FACILITY)

Record any direct costs applicable to the nursing facility to the appropriate cost center line item in the Expense Statement (pages 1–7). Use the Non-Nursing Facility line item to report costs from the hospital to the appropriate cost center.

NURSING FACILITY/NURSING SERVICE (page 6 of 7)

Director of Nursing, Nursing Supervisors, Managers, Ward Clerks, etc. – Report under Nursing Administration on page 4 of 7. Only direct nursing care hours and wages should be reported here.

CONTRACT NURSING – Report contract nursing costs to **column 2** of worksheet A.

EMPLOYEE BENEFITS – Report employee benefits in the applicable cost center. If employee benefits cannot be readily identified by cost center, then report total employee benefits on page 1 of 7.

Employee benefits, if offered to substantially all employees may include but are not limited to:

1. Employer's share of payroll taxes
2. State and federal unemployment contributions
3. Workers' compensation insurance
4. Group health and life insurance
5. Employee "non-cash" gifts
6. Moving/relocation expenses
7. Employee retirement plans
8. Employee parties, except alcoholic beverages
9. Profit sharing
10. Physical examinations
11. Malpractice insurance that specifically protects employees. This shall be specifically defined on the insurance bill from the agent.
12. Employee uniforms
13. Employee meals

Employee benefits shall **not** include:

1. Employee cash bonuses and/or incentive awards – these payments shall be considered additional compensation and be reported on Salary lines.
2. Benefits given to owner/related parties but not to substantially all employees – these benefits shall be treated as additional compensation and be reported on Owner/Related Party Compensation lines.

BED FEE TAX – The bed fee tax will be allowed if it is reported in the Administrative and General line item (SNF only providers) or directly to the Skilled Nursing Facility (SNF) and/or the Nursing Facility line items for facilities combined with hospitals.

SOCIAL SERVICE AND ACTIVITIES (Combined Facilities Only) – If the combined facility separates out the costs for social service and activities between the hospital and the nursing home, the facility should set up separate cost centers on worksheets A, B, and B-1 (Cost Center for Hospital – Social Services and Cost Center for Nursing Home – Social Service) to allocate these expenses. The nursing home costs can be allocated to the SNF and/or Nursing Facility line items on worksheet B-1.

NONREIMBURSABLE AND NONALLOWABLE COST AREAS – Direct costs must be listed on page 7 under Nursing Facility/Non-Reimbursable. General service costs are then distributed to these cost centers in the routine step-down process. Revenue from these activities must not be offset against the non-allowable cost centers prior to or during the cost finding process.

D. **FORM DPHHS MA-008D INTEREST EXPENSE STATEMENT**

Provide information on all bonds, loans, notes and mortgages payable.

Column (1) – Enter the original date and duration of the loan.
Column (2) – Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.
Column (3) – Enter the amount of the loan.
Column (4) – Enter the unpaid principal balance at the end of the cost period.
Column (5) – Enter the total amount of interest and principal payments made during the cost report year.
Column (6) – Enter the total amount of interest incurred during the cost report year

E. **FORM DPHHS MA-010 ADMINISTRATOR'S COMPENSATION QUESTIONNAIRE**

This two-page form must be completed for each person who served as Administrator during the cost report period. Each item on this questionnaire must be answered. Special attention should be paid to listing salary paid to the administrator and types and amounts of benefits paid for his/her benefit.

F. **FORM DPHHS MA-011 NURSING FACILITY COST REPORT QUESTIONNAIRE**

Each item on this questionnaire must be answered.

G. **FORM DPHHS MA-014 NURSING FACILITY PATIENT CENSUS**

1. **PART I (page 1) – PATIENT CENSUS:**

History of Bed Changes: If a change in the number of beds has occurred during the reporting period, show the increase (or decrease) and the date of the change.

LICENSED BEDS column: Indicate the number of licensed beds authorized by the Department of Health and Environmental Sciences for the cost reporting period. A change in licensure during the period should be noted as to the effective date and the licensed beds both before and after the change. If applicable, provide a history of licensed bed changes in the chart provided.

CURRENT CENSUS column: Indicate the actual patient census on the last day of the reporting period.

AVAILABLE DAYS column: Indicate the product of licensed beds multiplied by the total days in the reporting period.

ACTUAL DAYS column: Show the total occupied patient days for the reporting period. The total days in this column must agree with the total days shown in Part II.

Each question at the bottom of page 1 should be answered.

2. PART II (page 2) – MONTHLY CENSUS INFORMATION

MEDICAID column: Indicate the Medicaid rate and days billed and paid by month of service. This column should be used for days billed and paid during the normal cycle. Those days billed after the regular billing for the month and/or paid in a later month should be entered in the Retroactive Medicaid column. **Do not include co-insurance days.**

RETROACTIVE MEDICAID column: This column should be used for all days of service during the cost report period that were billed to Medicaid or paid by Medicaid outside of the normal monthly billing cycle. For example, March days not paid until May if a resident was determined retroactively Medicaid eligible because of the eligibility determination process, the retroactive Medicaid days billed in a later month should be entered in the month of service. Also, this column should be used for all days of service billed to Medicaid during the cost report period but still pending and unpaid as of the date the cost report is prepared.

MEDICARE COINSURANCE DAYS PAID BY MEDICAID column: Enter the rate and the number of Medicare Coinsurance days that were paid by Medicaid for each month. These days should be deducted from the Medicare column so that they are not double counted.

PRIVATE PAY column: The number of private days at each private and semi-private room rate should be shown in this column. The incremental charge above the semi-private room rate for private rooms should be attached for those months having more than two private pay rates.

MEDICARE column: Enter the Medicare rate and patient days for each month. A patient day should be considered a Medicare day if Medicare makes payment for that day.

OTHER column: This column should be used only for those patient days which do not fit into any of the other categories. The primary example is Veterans Administration (VA) patient days.

SWING BED column: Enter the Swing Bed rate and patient days that were billed to Medicaid for each month.

THV AND HH row: Enter the total Therapeutic Home Visit and Hospital Hold days that were billed to **Medicaid** for the fiscal year. Also enter the rate that was billed.

TOTAL column and row: Total the days by row for each month and record in the Total Days column. Total the days for each pay column and enter in the Total row. Total days for the period, **excluding swing bed days**, must agree with the total actual days in Part I. Do not include swing bed days in the total occupied days.

AVERAGE RATE column: Enter the average rate for the cost report period in each individual census column.

H. FORM CMS-2540-96 or CMS-2552-96

Providers are required to complete the CMS-2540-96 worksheets as indicated on the Medicaid Cost Report Worksheet Checklist or other appropriate CMS approved computerized worksheets.

1. WORKSHEETS, PART I – CERTIFICATION:

ARM 37.40.346 (4)(f) requires that cost reports shall be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider or an authorized officer of a corporate provider. The cost report certification should be submitted with an **original signature** rather than a copy of the signature.

2. WORKSHEET A:

Enter the total Salaries Expense and/or Other Expenses from the Expense Statement (pages 1–7) into the appropriate cost center(s). Enter any adjustments made on worksheet A-6 and/or A-8, foot and cross-foot the worksheet as instructed.

3. WORKSHEET A-6:

Enter any reclassification of expenses that are considered necessary to properly report direct costs. Do not reclassify allocation of general service costs on worksheet A. Summarize the reclassifications by cost center/line number, and post to column 4 on worksheet A.

4. WORKSHEET A-7:

Enter the beginning balances of Property, Plant & Equipment and any Purchases and/or Disposals. Foot and cross-foot the worksheet as instructed.

5. WORKSHEET A-8:

Enter any adjustments of expenses that are considered necessary. Offset amounts received from the State of Montana under the Lien and Estate Recovery Program if the one-time expenditures were expensed. Summarize the adjustments by cost center/line number, and post to column 6 on worksheet A.

6. WORKSHEET A-8-1:

All costs of services and supplies from related organizations must be adequately disclosed on worksheet A-8-1. Such costs are subject to disallowance if not disclosed. If this form is not applicable, mark it as such, and return it with the rest of the cost report forms.

7. **WORKSHEET B, Part I, Part II, Part III (if applicable) and B-1:**

   These worksheets are to be completed by providers who render services or incur costs other than for Routine Nursing Services. Non-routine services and costs include, but are not limited to, Physical Therapy; Ancillary Supplies and Drugs; Personal Care Services; Beauty and Barber Shop; Cafeteria; etc. If the total non-routine costs are greater than or equal to 1% of SNF costs than these worksheets must be completed. **Providers are advised that the Department will reject cost reports as incomplete if these worksheets are not properly prepared or if an alternative method is submitted without prior approval from the Department. NOTE:** The short form cost report step-down for Medicare (2540-S) is not acceptable for Medicaid cost reporting purposes.
8. **WORKSHEET G, G-1, G-2, and G-3:**

   The submission of these worksheets is required. Financial statements may be submitted as an attachment with the worksheets. Financial statements **may not** be substituted for these worksheets.

I. COPY OF PROVIDER'S TRIAL BALANCE

Providers are **required** to submit a complete, legible copy of their trial balance as of the ending date for the cost report period. Government facilities (County) should submit the Revenue and Expense detail report that applies to the nursing facility.

J. COPY OF PROVIDER'S DEPRECIATION SCHEDULE

Providers are **required** to submit a complete, legible copy of their depreciation schedule as of the ending date for the cost report period.