Cost Reports

All facilities must submit a cost report, in duplicate, on or before the last day of the fifth (5th) month following the close of the reporting period. When the date of the cost report falls on a Saturday, Sunday, state or federal holiday, the cost report is due on the following business day. All PRTFs must file cost reports based on a standard year end as prescribed by the State Plan unless otherwise approved by the DOM. State owned facilities must file cost reports based on a June 30 year end. County owned facilities must file cost reports based on a September 30 year-end. All other facilities must use a standard year-end of December 31. Facilities may request to change to a facility specific cost report year-end, if the requested year-end is the facility's Medicare or corporate year-end. Cost reports must be prepared in accordance with the State Plan for reimbursement of Psychiatric Residential Treatment Facilities that is found in the Long Term Care State Plan. A copy of the Plan is available upon written request or on the DOM web site.

Cost reports that are either postmarked or hand delivered after the due date or extended due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. Providers that do not file a required cost report within six (6) months of the close of the reporting period will have their Medicaid Provider Agreement terminated.

Facilities beginning operations during a reporting year will prepare a cost report from the date of certification to the end of the sixth (6th) month of operation. Facilities will be paid the maximum rate for their classification until the six (6) month cost report is received and the rate is recalculated. A retroactive rate adjustment will be made based on the six month cost report effective the date of certification.

Facilities that undergo a non-related party change of ownership must file a cost report from the date of the change of ownership through the end of the third (3rd) month of ownership. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. ~~Facilities will be paid the maximum per diem rate for their classification until the rate is adjusted based on this initial cost report.~~ Pending receipt of a cost report, the new facility will be paid the base rate of the prior owner, excluding hold harmless payment and return on equity. The provider may request and, absent any good cause to deny, the executive director shall approve setting the new owner's interim rate using the maximum class per diem rate. Upon receipt of the 3-month cost report, a per diem rate will be established based on a desk review and will be effective retroactive to the first day of certification.

Field Review of Facility Cost Reports

The Division of Medicaid conducts periodic field level cost report financial reviews of selected facilities to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. The reviewers will include those persons engaged by the Division of Medicaid to conduct the reviews including, but not limited to, Division staff and contract personnel. As necessary, adjustments will be made to the cost reports reviewed based on the results of the reviews. Each adjustment will include a written description of the adjustment being made including the reason for and amount of the adjustment.

Retention of Records

Providers must maintain adequate documentation, including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program. The cost report

must be based on the documentation maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting.

Financial and statistical data must be current, accurate and in sufficient detail to support costs contained in the cost report. This includes ledgers, books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks, inventories, time cards, payrolls, basis for allocating costs, etc.) that pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, room numbers of residents, hospital leave days and therapeutic leave days.

Documentation should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant changes is made to the Division of Medicaid. This disclosure should be made as a footnote on the cost report and should include the effect(s) of the change. All documentation, including cost reports, must be maintained for a period of three (3) years after submission to the Division of Medicaid.

Providers must make available to the Division of Medicaid all documentation that substantiates the costs included in the facility cost report for the purpose of determining compliance with Medicaid policy. These records shall be made available as requested by the Division of Medicaid. All documentation, which substantiates the information, included in the cost report, including any documentation relating to home office and/or management company costs, must be made available to Division of Medicaid reviewers as requested by the Division. If the Division of Medicaid reviewers are required to travel out of state to conduct any part of the cost report review, the provider shall bear all expenses and costs related to this travel, including, but not limited to, travel and reasonable living expenses. Such expenses and costs will not be allowable on any subsequent cost reports.

Work Space

The provider is required to make available to the Division of Medicaid reviewers adequate work space and privacy at the appropriate location to conduct the review.

Rate Setting

DOM uses a prospective method of reimbursement. This method does not allow for retrospective settlements. The rates are determined from cost reports and appropriate audits. Standard rates will be redetermined annually in accordance with the Medicaid State Plan. In no case may the reimbursement rate for services provided under this manual exceed an individual facility's customary charge to the general public for such services in the aggregate except for those public facilities rendering such services free of charge or at a nominal charge.

DOM may adjust prospective rates pursuant to changes in federal and/or state laws or regulations. All Plan changes must be approved by the federal grantor agency. Based on allowable and reasonable costs, DOM establishes per diem reimbursement rates for each facility. Each facility is furnished a copy of Attachment 4.19-D of the State Plan that is also known as the Long-Term Care Reimbursement Plan. For additional information regarding PRTF's rate computation, contact the Bureau of Reimbursement at the Division of Medicaid.

Services and Charges

The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan. While the facility may set their basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate. Any items and services available in the facility that are not covered under the Title XVIII or the facility's basic per diem

rate or charge must be available and priced identically for all residents in the facility.

Payment during Admission and Discharge from the Facility

DOM allows payment for the date of admission to the PRTF. DOM does not cover the date of discharge from the facility. If a resident is discharged on the date of admission, the day will be covered as the date of admission. A Medicaid-eligible resident must not be charged for the date of discharge.

Private Room Coverage by Medicaid

The overall average cost per day determined from the cost report includes the cost of private rooms. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in our reimbursement rates and no extra charge will be made to the resident, his/her family or the Medicaid program. In accordance with 42 CFR 447.15, the Medicaid reimbursement will be considered as payment in full for the resident.

Hospital Leave

The following rules apply to hospital leave:

1. A 15-day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed may not be filled with another resident during the covered period of hospital leave.

2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

3. Facilities may not refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

Payment During Therapeutic Leave from the Facility

A temporary absence of a resident from a PRTF will not interrupt the monthly payments to the facility under the provisions as outlined below. The period of leave will be determined by counting, as the first day of leave, the day the resident left the facility. Each facility is required to maintain leave records and indicate periods of therapeutic leave days. Before a resident departs on therapeutic leave, the facility must provide written information to the resident and family member or legal representative explaining leave policies. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility.

The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours to twenty-four (24) hours constitutes a leave day.

2. Medicaid coverage of therapeutic leave days per fiscal year (July 1 to June 30) for a PRTF is eighteen (18) leave days.

3. Each therapeutic leave day taken each month must be reported on the billing mechanism.

4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of the leave, who participated in the leave, and the outcome of the leave.

A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

Termination of a Provider Agreement

When a provider agreement is TERMINATED, federal regulations provide that payments may continue for up to thirty (30) days to provide time for an orderly transfer of Medicaid residents. The facility must notify all Medicaid residents, families, and/or guardians in writing within forty-eight (48) hours of receipt by the facility of the decertification letter. The facility must also submit to DOM a current list of Medicaid residents along with the name, address and telephone number of the family and/or guardian and the resident's attending physician. Medicaid staff will also notify the resident's families and/or guardians and can assist both the families and the facility in making other living arrangements for the resident.