Cost Reports

All facilities must submit a cost report following the close of their standard reporting year of January 1st through December 31st, except for state and county operated facilities, which must report on their statutory fiscal years ending June 30th and September 30th, respectively. A facility may elect to change their cost reporting period to match the Medicare or home office period. When the due date of the cost report falls on a Saturday, Sunday, state or federal holiday, the cost report is due on the following business day. Cost reports must be prepared in accordance with the State Plan for reimbursement of long-term care facilities. A copy of the Plan is available upon written request and on the website at www.dom.state.ms.us. All cost reports are due by the end of the fifth calendar month following the reporting period. Failure to file a cost report by the due date or the extended due date will result in a penalty of $50.00 per day and may result in the cancellation of the provider agreement.

Facilities beginning operations during a reporting year will prepare cost reports from the date of certification of participation to the end of their initial three (3) month operation period. DOM may lengthen the reporting period of the initial cost report to not more than six (6) months. Pending receipt of a cost report, the new facility will be paid the maximum established class rate. Upon receipt of the three (3) month cost report, due not later than five (5) months after the end of the cost report period, a per diem rate will be established based on a desk review and will be effective retroactive to the first day 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 month of ownership. DOM 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. 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. ~~Or upon request, the interim rate will be set at the maximum established class rate.~~ 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 desk review and will be effective retroactive to the first day of certification.

DOM uses a prospective method of reimbursement. The rates are determined from cost report data. Standard rates are determined annually with an effective date of January 1.

In no case may the reimbursement rate for services provided under this manual exceed an individual facility's customary charges 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.

Prospective rates may be adjusted by DOM pursuant to changes in federal and/or state laws or regulations. All State Plan changes must be approved by the federal grantor agency. Each facility is furnished a copy of Attachment 4.19-D of the State Plan, which is also known as the Long Term Care Reimbursement Plan.

Prospective rates may be adjusted by DOM based on revisions to allowable costs or to correct errors. These revisions may result from amended cost reports, field visit reviews, or other corrections. Facilities are notified in writing of amounts due to or from DOM as a result of these adjustments. There is no time limit for requesting settlement of these amounts. This policy is applicable to claims for dates of service since July 1, 1993.

For additional information regarding ICF/MR rate computations, the Bureau of Reimbursement of the Division of Medicaid should be contacted.

Field Review of Facility Cost Report

The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities (nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities) to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. The reviewer will include those persons engaged by the Division of Medicaid to conduct the reviews including, but not limited to, Division of Medicaid staff and contract personnel. Adjustments will be made as necessary to the reviewed cost reports 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, and basis for allocating costs, etc.) that pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, resident's room numbers, hospital 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 reports 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.