

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
Office of Research, Assessment and Accountability
Bureau of Audit

AUDIT WORK PROGRAM – Full Scope

Provider
Name _____

Provider
Number _____

Cost Report Period _____

Audit Date _____

Section of Work **AUDIT REQUIREMENT**

Pursuant to the Ohio Revised Code 5111.27, the department may conduct an audit of any cost report, and shall notify the nursing facility or intermediate care facility for the mentally retarded of its findings.

Audits shall be conducted by auditors under contract with or employed by the department. The decision whether to conduct an audit and the scope of the audit, which may be a *desk or field audit*, shall be determined based on prior performance of the provider and may be based on a Risk/Cost Analysis or other evidence that gives the department reason to believe that the provider has reported costs improperly. A *desk or field audit* may be performed annually, but is required whenever a provider does not pass the Risk/Cost Analysis tolerance factors. The department shall issue the audit report no later than three years after the cost report is filed, or upon the completion of a *desk or field audit* on the report or a report for a subsequent cost reporting period, whichever is earlier. During the time within which the department may issue an audit report, the provider may amend the cost report upon discovery of a material error or material additional information. The department shall review the amended cost report for accuracy and notify the provider of its determination.

This audit work program is developed for use by auditors employed by or under contract with the Ohio Department of Jobs and Family Services (ODJFS), performing audits of long term care facilities participating in the Ohio Medicaid Program.

Moreover, this audit work program is merely a guideline for the auditor to follow. The auditor will have to exercise professional judgment throughout the audit process and adapt the scope and the specific procedures to be applied to the circumstances encountered. Changes from the audit procedures outlined in this program should be documented with the amended procedures and the auditor's rationale clearly set forth.

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Section of Work **OVER VIEW**

Materiality must be considered throughout the audit. Reliance is placed on the professional judgment of the auditor when determining scope amounts, cost centers and accounts to be tested and time constraints.

Work papers should include the identification of the provider name, provider number, audit period, audit subject, scope, auditor's initials, date performed and workpaper identification as a part of the heading. Test items include vendor name, check number, check date, check amount, amount charged to the cost center, invoice number, invoice date, invoice amount, the description of the item invoiced, and proposed adjustment (if any), as well as reason for the adjustment (rule reference with explanation).

Documentation consists of invoices, canceled checks, provider produced documents, memos, public records, third party confirmations, and photocopies of data, corporate minutes, stock register, leases, purchase agreements, insurance policies, professional licenses, contracts, tax filings/payments, construction draws/affidavits, loans/interest and other forms of inspections and confirmations.

Wrap-Up of the audit consists of the completion of the proposed cost adjustments (PCAs) on the ODJFS form, and includes identification of the work paper reference, the cost report account number, adjustment number, audit narrative number, adjustment <credit> or debit, and complete/brief description of the proposed adjustment. Due professional care is to be exercised in the application and selection of all adjustment narratives. The auditor should recognize proposed adjustments are subject to the administrative appeal process. It is possible a provider may disagree with the auditor's findings. If so, this may require the auditor to defend his decision in a Chapter 119 Hearing or in court. Therefore, it is required all adjustments be supported by sufficient competent evidential matter.

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Section of Work **OVERVIEW**

Report writing by the auditor includes the completion of the index of work papers and memos comprising the completed auditor pack. Although the ODJFS has a standardized automated audit report, there may be instances where special narratives are warranted. For example, there may be items that the auditor note, which may be worth mentioning in the audit report to advise the provider of potential problems, although it may not have a fiscal impact in the current year. It is the responsibility of the auditor to ensure the audit report is complete and accurate.

Reference Materials. The cost reports are required to be completed in conformance with Ohio Medicaid rules and regulations. These regulations should be applied in the following order:

Medicaid's Hierarchy of Rules

1. **Ohio Revised Code (Chapter 5111)**
2. **Ohio Administrative Code (Rule 5101:3-3)**
3. **Code of Federal Regulations**
4. **Centers for Medicare and Medicaid Services (CMS) Publication 15-1 formerly titled Health Care Financing Administration Publication 15-1 (HCFA Pub. 15-1), a.k.a., Health Insurance Manual (HIM) 15**
5. **Generally Accepted Accounting Principles**

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Section of Work **PLANNING (PL)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>Overview</u></p> <p>Audit planning involves developing an overall strategy for the conducting and determining the audit's scope. The nature, extent and timing of planning vary with the size and complexity of the entity, experience with the entity, and knowledge of the entity's business. In planning the audit, the auditor should:</p> <p><u>Procedures</u></p> <ol style="list-style-type: none"> 1. Review the provider's permanent file. This includes, but is not limited to the following: <ol style="list-style-type: none"> a. Contracts, if any b. Financial statements -- audited or unaudited c. Review prior years audit work papers and findings. Determine which adjustments may affect current period. Make copies of any applicable audit working paper. d. Determine the status of any administrative appeals (Requests for Final Rate Recalculation Conference or Administrative Hearings, Chapter 119 or Court of Common Pleas) and rate considerations. e. Review cost report schedule C-3, Question 5 for other related facilities and Questions 1 and 2 for the provider's disclosure of transactions with and amounts paid to related organizations. Where provider has disclosed transactions with a related entity, identify the account in which expenses are reported and include accounts in the accounts sampled in examination of Expenditures Other than Payroll Expenses. 			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 1: <u>Procedures</u></p> <p>f. Determine whether the provider's financial information is stored electronically or hard copy and the provider's willingness to provide his financial records electronically.</p> <p>2. Obtain from ODJFS the cost report for the period under audit. Tie (reconcile) the cost report to the provider's working trial balance. Request from the provider a copy of the general ledger. Tie the general ledger to the trial balance and general ledger. Obtain explanations and supporting documentation for any*material differences. Any undocumented difference reported as an allowable cost is adjusted (Proposed Cost Adjustments (PCAs) from provider's reported allowable cost.</p> <p>*Material Difference for this Procedure is any difference equal to or greater than \$.01 per resident day (Difference/Total Inpatient Days).</p> <p>3. In reconciling cost report to trial balance, review for proper reporting of cost pursuant to Chart of Accounts, Appendix A of Rule 5101:3-3-20.1 of the OAC. Discuss with provider any discrepancies found. Any conflicting discrepancy which is not adequately explained and documented reclassified to proper reporting category, pursuant to Appendix A of Rule 5101:3-3-20.1.</p> <p>4. Review Attachment 2 of the Cost Report in conjunction with your examination of provider's</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 4: <u>Procedures</u></p> <p>trial balances of expenses and revenues. Observe Adjustments made to Attachment 2 and affected accounts. Ascertain whether or not provider has properly offset revenues and non allowable expenses. If proper offsets have not been reflected make the appropriate proposed cost adjustments.</p> <p>5. Obtain from provider a copy of his Medicare Audit Report(s) covering the reporting period of cost report. Review audit report for adjustments/findings which affect the reported cost. Identify affected accounts and include as accounts sampled in examination of expenditures other payroll expenses.</p> <p>6. Review Cost Report Schedule, Attachment 7, "Addendum for Disputed Cost", to determine if provider is reporting cost that is in dispute with Medicaid Rules and Regulations. If provider has reported/identified cost on Attachment 7, contact the Contract Administrator for a copy of the Bureau of Long Term Care Facility's (LTC) letter responding to provider's entry. Determine whether provider has reported his cost according to LTC's letter. If provider has reported cost differently, make the necessary proposed cost adjustments to agree with LTC's letter.</p> <p>7. Contact provider and conduct preliminary discussions regarding audit's scope and initial identification of records and documents to be examined. Make arrangements regarding timing of audit and work space requirements. In scheduling the Entrance Conference and the start of field work, allow the provider two (2) to three (3) weeks to</p>			

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Section of Work **PLANNING (PL)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 7: <u>Procedures</u></p> <p>prepare and make available the documents requested. Determine the audit's location, the availability of records and providers' representative during audit (i.e., if someone other than cost report preparer). Follow up with letter confirming audit's start date, period audited, date and time of entrance conference, provider's representative during audit, audit location, and records that should be available for audit.</p> <p>8. Prepare a memo summarizing your results and any discussions held with provider or his representatives. Post any proposed cost adjustments (PCAs) to PCA sheet with brief explaining reason for adjustment and rule supporting adjustment.</p> <p>9. Supervisory Review</p> <p>10. Clear Review Points</p>			

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Section of Work **GENERAL (G)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>Overview</u></p> <p>The audit procedures contained in this work program are designed to assure that reported costs are allowable, reasonable and related to resident care as follows:</p> <ul style="list-style-type: none"> • To ascertain the provider is conforming to rules and regulations governing reimbursement of cost. • To review, analyze, test and verify the provider's financial and statistical records. To determine only proper items of cost applicable to provider's services have been included in reimbursable cost. • To verify on a selective basis expenses attributable to the program have been reasonably determined. • To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation data are sufficient to properly develop valid and accurate statistical information. <p><u>Procedures</u></p> <p>1. Conduct an entrance conference with appropriate facility representative. Discuss audit objectives and time requirements. Orient yourself with the record keeping of provider.</p>			

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Section of Work **GENERAL (G)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<u>Procedures</u>			
2. Familiarization and orientation. Tour facility (Medicaid Certified) noting areas used by Medicaid residents and comparability with other areas (Non Medicaid Certified) used by non Medicaid residents. Inquire and take note of recent additions of building or equipment.			
3. If nursing home is audited by an independent accountants, request access to his audit work papers and obtain copies of his report to determine the extent of reliance, if any that can be placed on the independent auditor's work.			
4. Clerically test the prepared trial balances (TBs) and tie assets and liabilities TBs to the general ledger maintained by provider or report of an independent public accountant. Revenues and costs and expenses trial balances should be tied to general ledger on a 100% basis.			
5. Prepare and maintain a budget time control.			
6. Review all minutes of all Board of Directors (partners) and major committee meetings during periods under audit. Have provider complete Minutes Representation form.			
7. Have provider complete Related Party Questionnaire. Review related party transactions critically for propriety And allowability of reported cost, pursuant to OAC Rule 5101:3-3-01 (BB).			
8. Amend work programs and scopes as necessary based on this review. Document reason for any omitted step,			

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Section of Work **GENERAL (G)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 8: <u>Procedures</u></p> <p>modified, or those that could not be performed. Also, document reasoning behind any modified steps.</p> <p>9. Review and supervision.</p> <p>10. Clear review points.</p>			

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Section of Work **ASSETS, EXCEPT PROPERTY (A)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>Overview</u></p> <p>Profit providers may be reimbursed a Return on Equity, which is computed using allowable Assets and Liability accounts, pursuant to CMS Pub 15-1, Chapter 12. Testing of Assets can be passed for nonprofit providers, since they are not entitled to return on equity reimbursement. Testing of Assets can be passed upon for profit providers having zero or negative equity, since no reimbursement is received. Caution should be exercised when passing, since Assets may affect reported expenditures. If passed, write a memo explaining the reasons and indicates that the general ledger asset accounts were scanned for amortized or depreciated non-allowable assets.</p> <p>The procedures contained within this section provided reasonable assurance that reported asset balances are allowable pursuant to CMS Pub 15-1, Chapter 12, as follows:</p> <p><u>Procedures</u></p> <p>1. Examine the Asset Trial Balance for following:</p> <p>Material change in Account Balances – comparing ending account balance to beginning. The difference (ending minus beginning), if greater than 25% of beginning account balance (+or -) or \$100,000 which ever is greater; obtain an explanation for change, where account is not specifically reviewed through an audit procedure. The Material Change should be in accordance with Medicaid’s hierarchy of rules and regulations. Any material change not adequately explained and documented is adjusted from provider’s allowable equity as unsupported cost, pursuant to CMS Pub. 15-1, Section 2304. Omit this procedure, when provider has reported no beginning account balances</p>			

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Section of Work **ASSETS, EXCEPT PROPERTY (A)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 1 Procedures</p> <p>and this is his first reporting period for Medicaid.</p> <p>2. Savings Account</p> <p>Review and obtain documentation supporting Reported account balances. Tie supporting documentation to trial balance account. Any undocumented or unsupported difference is adjusted from provider's allowable equity reimbursement. Review for Excess Cash – not used in providing resident care, pursuant to CMS Pub. 15-1, Section 1218.2, Invested Funds. As a general guideline, if total cash on hand exceeds three (3) months of provider's total annual operating expenses, then amount in excess is disallowed from provider's allowable equity as Invested Funds, pursuant to CMS Pub. 15-1, Section 1218.2. Total operating expense includes both allowable and non allowable expenses. For purpose of determining excess cash, total operating expenses will include non allowable expenses in computation.</p> <p>3. Check Accounts</p> <p>Determine that provider reconciles bank accounts monthly, obtain and review reconciliations for last month of reporting period. Review bank reconciliation for any large and unusual reconciling items. Tie reconciliations to bank statements and trial balance for agreement. Any differences are adjusted from provider's allowable equity pursuant to CMS Pub. 15-1, Section 2304 as Unsupported Cost Data.</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<u>Procedures</u>			
<p>4. Account Receivables</p> <p>Obtain a detailed accounts receivable listing as of the end of the cost reporting period. Foot and tie to trial balance. Review and obtain explanation and documentation for any material* account balances or unusual items. Any unsupported difference or unusual item not explained and documented is adjusted from provider's allowable equity, pursuant to CMS Pub. 15-1 Section 2304, Inadequate Cost Data.</p>			
<p>5. Bad Debt Accounts</p> <p>Review both general ledger and trial balance , if bad debt Account reported obtain an analysis of the bad debt reserve and determine that bad debt expense is not included in reportable costs. If provider's included Bad Debt expense in allowable cost, adjust the reported expense from reimbursable cost pursuant to CMS Pub. 15-1, Chapter 300.</p>			
<p>6. Review the Trial Balance and General Ledger for following accounts, obtain documentation if reported and determine allowability pursuant to CMS Pub. 15-1 Chapter:</p> <ul style="list-style-type: none"> • Receivables between related organizations • Invested Funds • Funded Depreciation Accounts • Prepaid Life Insurance • Self- Insurance Reserve Fund • Gifts and Grants 			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 6: <u>Procedures</u></p> <ul style="list-style-type: none"> • Goodwill • Covenants not to Compete • Other Intangibles <p>In general, all of the listed are non allowable pursuant to CMS Pub. 15-1, Chapter 12 . However, exceptions are made where based on circumstances the account may be allowable. For example, life insurance on key officers of organization in order to secure to debt, the prepaid account for life insurance would be allowable. Again, it is necessary to document the existence and provider's intended purpose to determine allowability.</p> <p>7. Determine provider's policies regarding inventorying versus expensing of supplies and determine if such policies are consistently applied . Determine policies regarding physical inventories and if taken at end of reporting periods obtain supporting documentation. Clercially test and tie supporting documentation for inventory to trial balance and general ledger. Review for any usual items. Any difference is adjusted from provider's allowable equity, pursuant to CMS Pub. 5-1, Section 2304, Inadequate Cost Data.</p> <p>8. Prepaid Accounts (such as prepaid life insurance, rent, utilities or other)</p> <p>Document and determine the allowability pursuant to CMS Pub. 15-1, Chapter 12. Review basis of amortization and ensure basis is reasonable.</p>			

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Section of Work **ASSETS, EXCEPT PROPERTY (A)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
continuation of 8			
<u>Procedures</u>			
9. Prepare Memo and Post Proposed Adjustments			
<p>Prepare memo describing work performed and steps omitted or modified and reasons for mission/modification. In posting proposed adjustments to adjustment sheet or auditor's check sheet, review cost report schedule E – page 1 of 2 to ensure provider has not made same adjustment. Proposed adjustments must have a brief narrative explaining reason and Rule cited for support.</p>			
10. Review and Supervision			
11. Clear review points.			
<p>* Material Accounts are equal to or greater than one percent (1%) of total of assets.</p>			

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Section of Work **PROPERTY (P)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>Overview</u></p> <p>The work performed will verify the cost and existence of major asset additions, that depreciation expense is reported on a straight basis and useful lives are established in a manner consistent with Appendix A of Rules 5101:3-3-51.1 for NFs and 5101:3-3-84.1 for ICFs-MR of the OAC. Leases are reviewed for transactions with Related Parties and the allowability of cost pursuant to Rule 5101:3-3-01 (BB) of the OAC. Non-related leases are reviewed/ examined on basis whether or not they meet the capitalizing criteria of FASB#13 and compliance with Rule 5101:3-3-51.5 of the OAC for NFs. Depreciable assets are allowable and used in providing resident.</p> <p><u>Procedures</u></p> <p>1. Obtain provider's listing of fixed assets as of the end of the cost report period.. Clerically test and tie to Trial Balance. Review critically for assets that are not used in providing resident care or of personal nature, such as vehicles, computers and telecommunication equipment. On test basis, in workpaper format, document additions, since the last period audited by performing the following:</p> <ul style="list-style-type: none"> • Select at least ten (10) additions for each calendar year, using the highest dollar amount as selection criteria. • Document the acquisition by examining the canceled check, invoice and may observe its physical presence. • Review the useful lives assigned for compliance and recompute the depreciation expense allowed. 			

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Section of Work **PROPERTY (P)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<u>Procedures</u>			
<p>2. Determine if facility and/or equipment are leased or rented. Determine if rent or lease agreements are with related parties. If leased or rented from a related party, depreciation expense should be based on related party's historical cost, instead of lease or rent payments. The related party's cost of financing the acquisition is allowable. Ensure provider's (NF/ICF-MR) equity reflects properly the Net Equity in transaction. Recompute the allowable net equity and agree to amount reported on cost report schedule E-1 page 1 of 2. Note, Rule 5101:3-3-01 (BB) of OAC provides for an exception, under following circumstances:</p> <p style="text-align: center;">After the facility has changed Ownership</p> <ul style="list-style-type: none"> • Provider transferring ownership must not have a direct or indirect interest in new provider's operations, such as officer, director, employee, independent contractor, or consultant. Only interest allowed is that of lessor. • Transferring provider does not reacquire an interest in new provider's operation's. <p>In event, you encountered a situation involving the exception; review how the parties are maintaining their business relationship. If Lessor gains direct or indirect interest in new provider's operation, then the old provider's historical cost for leased assets becomes the new provider's allowable cost. Prepare a memo documenting your examination.</p>			
3. For providers (NFs) new to Medicaid program on/or			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>continuation of 3 Procedures</u></p> <p>after May 27, 1992, ensure historical cost or lease payments agree with allowable amounts determined by Long Term Care. Support/Documentation should be obtained from Contract Administrator for audit verification.</p> <p><u>Note:</u> Rule 5101:3-3-20.1 of the OAC will require NFs new to Medicaid Program on or after May 27, 1992 to use following account numbers when reporting rent or lease payments or incurred cost of depreciation and interest expense of the facility's purchase price:</p> <ul style="list-style-type: none"> a. 8110 Depreciation – Building b. 8140 Depreciation – Equipment c. 8170 Interest - Property, Plant & Equipment d. 8195 Lease Expense <p>Trace allowable cost from LTC's Letter to provider's depreciation schedule. Obtain explanation for any material differences. Differences not in accordance with LTC's Letter, if reported as allowable cost are disallowed.</p> <p>4. Examine lease agreements, where cost has been reported in cost report account numbers 8060, Lease and Rent – Building and 8065, Lease and Rent - Equipment to determine if capitalization criteria of FASB #13 is met.</p> <p>5. For providers having additions to Renovations, cost report account number 1300, which were acquired subsequent to December 31, 1993, obtain from the Contract Administrator LTC's Nonextensive Renovation Approval</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 5: <u>Procedures</u></p> <p>Letter. Trace the information from approval letter to depreciation schedule. For differences between LTC's approval letter and amounts reported for reimbursement reference Rules 5101:3-3-51.3 (F)(1) and (2) for NFs and 5101:3-3-84.3 (F) and (2) ICFs-MR and 5101:3-3-01 (EE of the OAC) to ensure compliance. Differences exceeding twenty (20) thousand dollars for NF or two (2) thousand dollars for ICFs-MR of the first approval will require a second approval letter from LTC. Obtain from the provider a copy of the second approval letter. Trace the approved amount to difference. The amount in excess of the approval or amounts requiring LTC's approval, where approval was not sought, are reclassified to cost of ownership. If financed, the associated interest expense is reclassified to cost of ownership, also.</p> <p>6. Transportation Expenses – Lease and Depreciation Expense</p> <p>Ensure that reported expenses are allowable and reasonable. Luxury vehicles and vehicles used solely by owners and corporate officers are not reported as additional compensation pursuant to CMS Pub. 15-1, Chapter9; are adjusted from allowable cost pursuant to CMS Pub. 15-2, Section 2102.3. Reasonable cost basis is \$40,000 per vehicle.</p> <p>7. Review provider's asset lives and depreciation method on a test basis. Ensure depreciation method and useful lives conform with Rules 5101:3-3-51.1 for Nfs and 5101:3-3.84.1 for ICFs-MR of the OAC. Tie depreciation expense on an overall basis by asset class (Cost of</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p>continuation of 7: <u>Procedures</u></p> <p>Ownership, Renovation and Assets Acquired through Ownership Change) to Trial Balance.</p> <p>8. Prepare Memo and Post Proposed Cost Adjustments (PCAs) – prepare memo outlining work procedures and steps omitted or modified and reasons for omission/modification. Ensure, PCAs are cross referenced to cost report schedule D column 4 adjustments to avoid duplication of provider’s self imposed adjustments. Post PCAs to sheets with brief narrative explaining reason and rule cite.</p> <p>9. Supervision and review.</p> <p>10. Clear review points.</p>			

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Section of Work **LIABILITIES (L)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>For Non Profit Providers</u>, except where transactions may affect filed cost, pass on the program procedures.</p>			
<p><u>Overview</u></p> <p>Profit providers may be reimbursed a Return on Equity, which is computed using allowable Assets and Liability accounts pursuant CMS Pub. 15-1 Chapter 12. Testing of Liabilities can be passed for nonprofit providers, since they are not entitled to return on equity reimbursement. Testing of Liabilities can be passed upon for profit providers having zero or negative equity, since no reimbursement is received. Caution should be exercised when passing, since Liabilities may affect reported expenditures. If passed, write a memo explaining the reasons and indicate the general ledger liability accounts were scanned for interest bearing non-allowable accounts and the expense was not reported as allowable cost .</p> <p>The procedures contained within this section provided reasonable assurance that reported liability account balances are properly stated, allowable pursuant to CMS Pub 15-.1, Chapter 12.</p> <p><u>Procedures</u></p> <p>1. Examine the Liability Trial Balance for following:</p> <p style="padding-left: 40px;">Material change in Account Balances</p> <p>Comparing ending account balance to beginning. The difference (ending minus beginning), if greater than 25% of the beginning account balance (+or -) or \$100,000 which ever is greater; obtain an explanation for the change, where the account is not specifically reviewed through an audit procedure. The Material Change should be in accordance with Medicaid's hierarchy of rules and</p>			

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Section of Work **LIABILITIES (L)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>For Non Profit Providers</u>, except where transactions may affect filed cost, pass on the program procedures.</p>			
<p>continuation of 1: <u>Procedures</u></p> <p>and regulations. Any material change not adequately explained and documented is adjusted from provider's allowable equity as unsupported cost, pursuant to CMS Pub. 15-1, Section 2304. Omit this procedure, when provider has reported no beginning account balances and this is his first reporting period for Medicaid.</p> <p>2. Accounts Payable</p> <p>Obtain copy of accounts payable detail for cost report period end date. Foot and tie to trial balance. Review and obtain explanations for large or unusual items.</p> <p>3. Medicaid Payable</p> <p>Material accounts (5% of or greater than total liabilities). Obtain and document explanation given. Obtain documentation which identifies last service date, resident name and number. If 9400 filed and not acted on, obtain copy. In separate letter to contract manger, identify provider name and number, resident name and number and last service date and copy of 9400.</p> <p>4. Payroll Accruals – tie to payroll register and</p>			

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Section of Work **LIABILITIES (L)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>For Non Profit Providers</u>, except where transactions may affect filed cost, pass on the program procedures.</p>			
<p>continuation of 4: <u>Procedures</u></p> <p>recomputed accuracy as part of Payroll Test.</p> <p>5. Notes and Mortgage Payables - Review and prepare a schedule of provider's interest bearing notes and mortgage payables identifying date incurred, amount, interest rate, balance at December 31st and purpose of the loan. The purpose must be related to resident care for related interest expense to be allowable. Tie reported balances and interest expense to trial balance.</p> <p>6. Loans from Owners or Stockholders</p> <p>Scan trial balance and general ledger for loans from owners or stockholders. If reported, inquire as to loan's purpose and need. Determine if interest expense if reported is allowable. If disallowed (interest expense), the loan should be removed from calculation of equity or recognized as additional invested capital, pursuant to CMS Pub. 15-1, Chapter; if reasonable and related to resident care.</p> <p>7. Test other liability accounts to extent deemed appropriate based on materiality. Materiality for this purpose are accounts equal to or greater than five percent (5%) of total liabilities.</p> <p>8. Determine the provider is on a proper accrual basis and that its accrual policies are consistent between periods. Cross reference this procedure to Subsequent Review.</p>			

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Section of Work **LIABILITIES (L)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>For Non Profit Providers</u>, except where transactions may affect filed cost, pass on the program procedures.</p>			
<p><u>Procedures</u></p>			
<p>9. Prepare Memo and Post Proposed Adjustments</p> <p>Prepare memo outlining procedures, conversations with provider, steps omitted or modified. Post adjustments to Proposed Cost Adjustment Sheet(s), review cost report Schedule E-1, page 1 of 2 to ensure adjustments do not duplicate provider's adjustments for Medicaid.</p>			
<p>10. Review and supervision.</p>			
<p>11. Clear review points.</p>			

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Section of Work **SUBSEQUENT REVIEW (SR)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	INDICATE PROGRAM CHANGES	WORKING PAPER REF.	TIME
<p><u>Overview</u></p> <p>Pursuant to Rule 5101:3-3-20 of the OAC profit providers are required to file the cost using accrual basis accounting. Governmental operated facilities may file using cash basis accounting. The work performed is to determine that provider has properly recognized his expenses in the proper period of occurrence and payables were properly established.</p> <p><u>Procedures</u></p> <ol style="list-style-type: none"> 1. For the first month of audit period, review and vouch 20 disbursements for each month. The selection of disbursements should be based on the highest dollar amount, excluding disbursements to payroll expenditure and payroll taxes. Trace expenditures to payable listing and account to ensure the proper entry has been made. 2. Prepare Memo and Post Proposed Cost Adjustments Prepare memo outlining procedures performed, conversations with provider and whether or not provider has properly accrued his reported expenditures to the period of occurrence. 3. Review and supervision 4. Clear review points. 			

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Section of Work **OCCUPANCY AND USAGE STATISTICS (OU)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Overview</u></p> <p>The accuracy of provider's reported Total Inpatient Days is essential, since it's the denominator used to calculate the provider's Medicaid per diem rate. The procedures will provide reasonable assurance that Total Inpatient Days have been properly reported.</p>			
<p><u>Procedures</u></p> <p>1. Tie Cost Report Schedule A-1 on a monthly basis to provider's census records by resident type. Differences should be explained and sufficiently supported by provider. Differences (Net Sum line 13, Column) not sufficiently explained and or documented are adjusted using the following criteria:</p> <ul style="list-style-type: none"> • If cost report greater than census - no adjustment required. • If cost report less than census – adjust report to census record. <p>2. Reporting of Medicaid Leave Days</p> <p>Inquire of the Providers procedure for reporting Medicaid Leave Days (deceased residents, therapeutic or hospital leave days), pursuant to Rule 5101:3-3-39 of the OAC. Prepare a memo identifying with who discussed and their Position describing the procedure. Inquire of outstanding Medicaid pending adjustments (Receivables or Liabilities), where provider has proper documentation (9400) showing dates of service acquire copies and submit separately to contract manager with cover identifying provider and number.</p>			

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Section of Work **OCCUPANCY AND USAGE STATISTICS (OU)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 2 Procedures</p> <p>Note: Medicaid Leave Days (Therapeutic & Hospital) are reported at 50% of inpatient day for NF and 100% for ICF-MR. Private, Medicare and Other Resident leave days are not reported as inpatient days.</p> <p>3. Haphazardly select 10% of medical records to test accuracy of census records. Prepare a schedule noting resident's name, payor type (Medicaid, Medicare, Private or Other), admission and discharge dates and total days resident was in providers' care for test month noted in Step 4 below. (Note: Rule 5101:3-3-20 (O)(3) of the OAC provides for the assessment of penalties, if access to medical records is denied)</p> <ul style="list-style-type: none"> • Determine whether the resident has been properly included in Census Reports by tracing resident from medical records to daily census listing and/or log for test month. <p>4. Select one test month from providers' census detail () and run an adding machine tape for:</p> <p>a. Total inpatient days</p> <p>b. Medicaid inpatient days</p> <p>Trace tape totals to census detail totals. Any discrepancies should be explained and documented by provider.</p> <p>5. Haphazardly select 10% of residents from provider's detail census report, using Month Selected in Procedure 4.</p>			

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Section of Work **OCCUPANCY AND USAGE STATISTICS (OU)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Continuation of 5 Procedures</u></p> <p>Trace resident's reported days to his medical record. Any differences between census detail and medical record should be explained by provider. Any unexplained difference is adjusted as in procedure</p> <p>6. Paid Medicaid Days in Excess of Total Inpatient Days The contract manager will identify providers where Total Inpatient Days are less than paid Medicaid Days (MMIS). Additional information will be provided by contract manager, where additional inquires of provider will be necessary to identify and obtain documentation supporting pending adjustments. Again, the provider should be able to identify the specific resident and provide a copy of the outstanding 9400 for support. Obtain copy(s), and submit cover letter to contract manager with copy(s) of 9400. Prepare memo documenting your discussion.</p> <p>7. Prepare Memo and Post Adjustments</p> <p>Prepare memo outlining procedures performed, procedures modified or omitted. Post adjustments to Proposed Cost Adjustment Sheet. Use A113 for account number when posting adjustments.</p> <p>8. Review and supervision.</p> <p>9. Clear review points.</p>			

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Section of Work **REVENUE (R)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Overview</u></p> <p>The Overall Objective of the Revenue Program is to provide reasonable assurance revenues are stated fairly in relationship to inpatient days and where appropriate the provider has offset cost for revenue generating expenses.</p>			
<p><u>Procedures</u></p> <ol style="list-style-type: none"> 1. Scan the Revenue Trial Balance for Non routine revenue accounts, for example dry cleaning, gain and loss on equipment sales, meals, interest income and other accounts non routine service accounts. Obtain and document explanations for accounts. 2. Inquire of the provider's the methods of accumulating resident charges. Write a memo describing the procedures. 3. Scan the Trial Balance for Interest Income and other Revenue Generating Expenses - Determine the source of interest income and whether or not interest expenses should be offset by interest income, pursuant to CMS Pub. 15-1, Chapters 2 and 5. Review attachment 2 of cost report to ensure any adjustment proposed does not duplicate the provider's. Scan revenue trial balance for other revenues earned (worker's comp. refunds, other refunds or credits on or for reported expenses or sale of depreciable equipment). Ensure provider has properly offset the expenditure pursuant to CMS Pub. 15-1, Chapters 1 and 8. 			

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Section of Work **REVENUE (R)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<u>Procedures</u>			
<p>4. Perform an overall proof of revenue (room & board) by multiplying resident days per census records by provider's schedule of room rates to determine recorded revenue are stated fairly. Obtain explanation for differences, which are greater than 5% of revenue account.</p> <p>5. Using the same medical records selected in Procedure 3 of the Occupancy and Usage Statistics Program trace the room and other ancillary charges to the resident's account to determine the charges for services are being recorded and are in agreement with appropriate rate schedules. Also, using same residents selected in Procedure 6 of the Occupancy and Usage Statistics Program trace their charges back to medical records. Obtain copies of rate charts for all central supplies sold, ancillary charge, etc. Ascertain how these charges are handled for Medicaid residents. Ensure, Medicaid residents are not charge amount for these services. If charged, prepare memo identifying resident record, amount and date of charge. Forward copy of memo to contract manager.</p> <p>6. Review all revenue accounts for revenues earned from non routine services and other operations not related to resident care. The associated cost for these services or operations must be deducted from operating expenses to arrive at allowable Medicaid costs. Ensure the provider has adjusted the reported cost for these services or operations, if not make the appropriate PCAs.</p> <p>7. Prepare Memo and Post Cost Adjustment(s) [PCAs]</p> <p>Prepare memo outlining procedures performed, procedures omitted or modified. Post PCAs to Proposed Cost</p>			

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Section of Work **REVENUE (R)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 7 <u>Procedures</u></p> <p>Adjustment Sheet with brief narrative stating reason(s) and rule cited.</p> <p>8. Review and supervision.</p> <p>9. Clear review points.</p>			

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Section of Work **EXPENSES (E)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<u>EXPENSES OTHER THAN PAYROLL</u>			
<u>Objective</u>			
The objectives of this program are:			
1. To determine that only allowable and reasonable cost, as defined by Rules 5101:3-3-01 (A) and (AA) of the OAC, applicable to the provider have been included in the filed cost report.			
2. To ascertain that records supporting statistical data and the adequacy of the methods used for accumulation data are sufficient to properly develop valid and accurate information.			
3. To consider the materiality of costs being audited, in relation to the possible dollar effect on reimbursement from the Medicaid Program.			
4. To be alert to the possibilities of goods and services acquired from related parties as defined pursuant to Rule 5101:3-3-01 (BB) of the OAC and assure appropriate expenses resulting from the transaction have been reported. Examples of goods or services provided by related party are pharmaceuticals, food, and laundry and contract services such as managerial and nursing services.			
Account Selection Criteria			
1. Prior audit findings, where current period account is examined to ascertain if provider has corrected reporting error.			

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Section of Work **EXPENSES (E)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Overview</u></p> <p>2. Risk/Cost Analysis, where material fluctuations exist between periods.</p> <p>3. Accounts having a high risk for miss reported cost.</p> <p><u>Procedures</u></p> <p>1. Scan trial balance considering materiality. Eliminate immaterial accounts from review. Material accounts are defined as representing five percent (5%) or more of total expenses per cost center, less expenses for payroll salaries, taxes and benefits.</p> <p>2. When testing expense accounts vouch at least fifty (50) percent of the account's disbursements. Selected disbursements are traced to the provider's supporting documents. Specific accounts tested are selected on the basis of Attachment 2, using Risk/Cost Analysis.</p> <p>3. In examining expenses, the Testing Parameters of Attachment 2 should be given special emphasis. Expense accounts are examined determine, if cost are properly classified according to Medicaid's Chart of Accounts, Rules 5101:3-3-20.1 and 5101:3-3-20.2 of the OAC, allowable, reasonable and used in providing resident care, pursuant to Rule 5101:3-3-01 (A) of the OAC.</p> <p>4. For volunteer services provided by individuals, including members of religious orders obtain a schedule identifying the salary and other allowances paid or imputed by account number. The requirements of CMS Pub. 15-1, Chapter 700 titled "Value of Services of Nonpaid</p>			

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Section of Work **EXPENSES (E)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 4 Procedures</p> <p>Workers" will apply in determining the allowable cost for the provided service.</p> <p>5. Review OAC Rule 5101:3-3-19 in conjunction with testing of Medical Expense Accounts (6000 through 6006) and following:</p> <p style="margin-left: 20px;">a. Determine whether reported cost is in accordance with rule.</p> <p style="margin-left: 20px;">b. Determine whether appropriate schedule A 2- offset, or revenue offsets were made.</p> <p>Also, these same accounts have a high risk for inappropriate expenses, such as legend drugs, leasing of complex medical equipment, and supplies for incontinence, universal precautions and personal care. Again, Rules 5101:3-3-10 and 5101:3-3-20.1-Appendix A of OAC will provide general guidance on the proper account reporting and whether or not the cost should be direct to the department.</p> <p>6. Rent expense is examined for compliance with Paragraph (BB) of OAC Rule 5101:3-3-01, related parties, and FASB 13.</p> <p>7. Refer to procedure covering revenue. If expenditures are reported for ancillary services such as lab, x-ray, ambulance service, physical therapy, occupational therapy, speech therapy, audiology, physicians' salaries, etc.,</p>			

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Section of Work **EXPENSES (E)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 7 <u>Procedures</u></p> <p>determine the cost of these services and ensure they have been eliminate from allowable costs. Exception: For ICF-MR, Physical Therapy, Occupational Therapy, Speech Therapy and Audiology are allowable costs.</p> <p>8. Examine and document management fees paid or any similar costs to determine payee and nature of services provided, pursuant to CMS 15-1 Section 2135. Review for duplication of services, appropriateness of cost classification and whether services are provided by related entity. If duplication of services or improperly classified or provided by related entity, adjusted the reported cost accordingly, pursuant to paragraph (BB) of OAC Rule 5101:3-3-01.</p> <ul style="list-style-type: none"> • 6210 – Direct Consulting & Management Fees <p style="padding-left: 40px;">Ensure the reported cost are incurred at arms length and agrees with the account definition, Appendix A of Rule 5101:3-3-20.1 of OAC.</p> <p>9. Life Insurance and Personal Insurance of owners, officers and directors, where cost has been included in allowable cost, document following:</p> <ul style="list-style-type: none"> • Insurance company • Face amount • Policy number • Beneficiary • Amount included in providers' expenses 			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 9 <u>Procedures</u></p> <p>Premium costs are disallowed where provider is direct or indirect beneficiary. Premium costs are allowable if individual's relatives or estate is beneficiary as long as expenditures remain within guidelines of reasonableness, pursuant CMS Pub. 15-1, Section 2130. An exception does exist, if requirement to secure debt, pursuant to CMS Pub. 15-1, Section 2130.</p> <p>10. Expenses attributable to following revenue accounts (and similar items) are not included in allowable routine costs; scan general ledger and trial balance and ensure such items have been eliminated. If expense is not identifiable or cannot be segregated, then the revenue earned must be offset against the appropriate expense. The offset must not exceed the expense.</p> <ul style="list-style-type: none"> • Telephone service (pay stations excluded). • Radio and television service. • Routine laundry services to residents not of the facility. • Unrestricted investment income • Employee and guest meals. Exception, if employee meal meets the Fringe Benefit Test, pursuant to CMS Pub. 15-1, Section 2144 • Sale of drugs to other than patients (including going-home drugs) • Sale of medical and surgical supplies to other than patients 			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
continuation of 10			
<u>Procedures</u>			
<ul style="list-style-type: none"> • Sale of medical records and abstracts • Sale of scrap, waste, etc • Rental of quarters to employees and others • Promotional Advertising – CMS Pub 15-1, Section 2136 • Payments received from specialists • Trade, quantity, time and other discounts on purchases • Rebates and refunds of expenses – Workers’ Compensation • Fund-raising expenses • Private duty nurses • Vending machines • Bad debts • Income taxes • Recovery of insured loss • Expenses of operating gift shops, snack bars, etc. • Penalties and interest on penalties • Any other expenses not applicable to resident care 			
<p>In conjunction with your review of trial balances and general ledger, ensure any proposed cost adjustment (PCA) does not duplicate a provider’s self adjustment from Attachment 2 of cost report or cost reported in 9000 account series.</p>			
<p>11. Examine and re-test basis and propriety of allocations, where the nursing home represents a distinct operation and cost are shared. Assured cost allocations are</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 11 Procedures</p> <p>reasonable pursuant to CMS Pub. 15-1, and report cost and expenses are allowable, reasonable and related to resident care. Examine Home Office Cost Account Numbers:</p> <p>6095 – Home Office Cost Other Protected Care Cost</p> <p>6230 – Home Office Cost Direct Care Cost</p> <p>7310 – Home Office Cost Indirect Care Cost</p> <p>8080 – Home Office Cost Capital Care Cost</p> <p>8290 – Home Office Cost Capital Care Cost</p> <p>12. Obtain from provider, if not previously provided by ODJFS, Home Office Trial Balances of Assets, Liabilities, Expenses, Revenues and Depreciation Schedules. Also, obtain copy of Revenues and Depreciation Schedules. Also, obtain copy of Provider's support for method of allocating cost and expenses and equity to components of chain. Determine the following:</p> <p>Assets</p> <p>Assure assets claimed in allocated home office equity meet same requirements of Assets Work Program. Use Asset Work Program Procedures assuring reported assets</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>continuation of 12 Procedures</u></p> <p>are allowable, reasonable and related to resident care. Prepare memo outlining procedures completed.</p> <p>Liabilities</p> <p>Assure liabilities claimed in allocated home office equity meet same requirements of Liability Work Program. Use Liabilities Work Program Procedures assuring reported liabilities are allowable, reasonable and related to resident care. Prepare memo outlining procedures completed.</p> <p>Property</p> <p>Assure depreciable assets and depreciation expense claimed meet same requirements as Property Work Program. Use Property Work Procedures assuring cost capitalized are allowable, reasonable and related to resident care and useful lives are consistent with Medicaid's guidelines Prepare memo outlining procedures completed.</p> <p>Payroll</p> <p>Assure payroll cost meet same requirements of Payroll Work Program. Use Payroll Work Program procedures assuring allowability of reported cost and reasonableness of highly compensated personnel. Prepare memo of work completed.</p>			

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Section of Work **EXPENSES (E)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 12 Procedures</p> <p>Revenues</p> <p>Scan the revenue trial balance for revenues, which are offset against reported expenses. Discuss with provider your observations and document their response. For offset adjustments, where the provider has failed to offset the proper amount, make the necessary PCA pursuant to Sections 804 and 2302.5 of CMS Publication 15-1.</p> <p>Expenditures other than Payroll</p> <p>Scan the home office trial balance for non-allowable expenses to OAC Rule 5101:3-3-01(A). Adjust from allocated cost any expenses that are non allowable. Select at least five material accounts to substantiate test the allowability of cost.</p> <ul style="list-style-type: none"> • Use a five percent (5%) materiality factor of total expenses, excluding payroll salaries and their associated taxes to identify material accounts. • Haphazardly sample 20 transactions for each account. Ensure the expense is allowable, reasonable, and related to resident care. Prepare a work paper documenting your work. <p>Home Office Allocations</p> <p>Assure allocation basis used is adequately supported and was rationally developed, pursuant to Section 2150 of CMS Publication 2150. Retest provider's allocation worksheets to assure cost have been accurately allocated. Where adjustments have been proposed, recalculated and</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continuation of 12 <u>Procedures</u></p> <p>compare to what has been reported to arrive at the correct PCA.</p> <p>13. Prepare Memo and Post Cost Adjustment(s) [PCAs] – prepare memo outlining procedures performed, procedures omitted or modified. Post PCAs to Proposed Cost Adjustment Sheet with brief narrative stating reason(s) and rule cited.</p> <p>14. Review and supervision</p> <p>15. Clear review points</p>			

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Section of Work Medicaid Paid Claims Test

Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Overview</p> <p>Pursuant to OAC Rules 5101:3-3-39 and 5101:3-3-39.1, the procedures are designed to provide reasonable assurance the provider has billed Medicaid appropriately for days of care, as follows:</p> <ul style="list-style-type: none"> • Confirm resident was in provider’s care for days paid • Confirm provider has billed Medicare for covered days and billable services • Confirm provider has not billed or Medicaid has not paid for days beyond resident’s date of death, discharge, transferred to another provider or the resident’s election to receive hospice care • Ensure Medicaid leave (therapeutic and hospital) days have been appropriately billed and paid according to provider type (NF or ICF-MR) <p>Procedures</p> <p>The contract manager will provide a detail MMIS claims report of the provider’s billing (NF’S) or payments (ICF-MR) for the fiscal year.</p> <p>1. Meet with the provider’s personnel who are responsible for resident billings to discuss and gain understanding of their billing process. Discuss the following with the responsible parties:</p>			

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Section of Work Medicaid Paid Claims Test

Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
Procedures			
<p>A. What process is in place to identify the appropriate party(ies) to bill for services rendered for the following resident types:</p> <ol style="list-style-type: none"> 1. Private 2. Medicare 3. Medicaid 4. Other Payors <ol style="list-style-type: none"> a. How is this information communicated for accuracy of billing? <p>B. Does a written policy or procedure manual exist concerning resident billings? If yes, obtain copy for audit file.</p> <p>C. Medicaid residents: What documentation is used and maintained identifying resident liability/resources?" Note: The appropriate documentation should come from the County Department of Job and Family Services.</p> <p>D. Medicaid residents: What's the entity's procedure for reconciling Medicaid payments to <u>identify over or under payments</u>? What is the process for resolving reconciling differences?</p>			

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Section of Work Medicaid Paid Claims Test

Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
Procedures			
<p>1. Medicaid Residents: Are there any outstanding Medicaid account receivable or liability amounts older than one (1) year?</p> <p>E. Medicaid Residents: What process ensures Medicare is appropriately billed for services incurred by Medicaid resident with Medicare Part B coverage returning from qualifying hospital stay Needing skilled care (rehabilitation)?</p> <p>F. Medicaid Residents: For residents with pending Medicaid's eligibility, how are their billings processed?</p> <p>1. What payor type would the revenues earned be recorded as?</p> <p>2. Retroactive Medication determination: How is the transaction processed? Are recorded revenues and census records adjusted to reflect Medicaid's eligibility determination?</p> <p>2. Using the MMIS claims report, haphazardly select the number of residents by provider type, as follows:</p> <p>A. NF – select 15 residents</p> <p>B. ICF-MR – select three (3) residents Include in haphazard selection residents with</p>			

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Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Procedures</p> <p>partial months of service, hospital leave days or not appearing on MMIS claims report for full period.</p> <p>3. For residents selected above, randomly select two (2) months throughout the period of the claims report for each resident, if MMIS claims report covers twelve (12) months to eight (8) months. If claims report is less than eight (8) months, randomly select one (1) month in the billing period for each resident; prepare work paper recording the following information.</p> <p>A. Claim control number – numeric 17 digits</p> <p>B. Medicaid billing number – numeric – 12 digits</p> <p>C. Recipient last name – alpha – 2- characters</p> <p>D. First date of service – numeric date format – 07/01/05</p> <p>E. End date of service – numeric date format – 06/30/06</p> <p>F. Date paid – numeric date format – 08/15/05</p> <p>G. Total days billed, excluding leave days – numeric</p> <p>H. Covered leave days – hospital and therapeutic – numeric with decimal for NF half-day</p> <p>I. Covered Medicare Part B days - numeric</p>			

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Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Procedures</p> <p>J. Resident liability –numeric dollar format with decimal for cents</p> <p>4. Using the recorded data in Step 3, agree paid Medicaid days to provider’s billing and resident medical records for selected months. Ensure the following are in agreement:</p> <p style="padding-left: 20px;">A. First and end dates of service – agree to medical record for months selected.</p> <p style="padding-left: 40px;">1. Review medical record for period of claims report for evidence of resident’s discharge, admittance to hospital, election to receive hospice care or death.</p> <p style="padding-left: 40px;">2. Ensure the provider has billed or was paid properly. Where differences/errors occur, make inquiry to determine reason. If adjustment submitted to ODJFS supporting difference, obtain copy of provider’s documentation and include difference on adjustment sheet with notation identifying support provided which may clear the adjustment. No documentation existing, reported as an adjustment to days paid, provide reason for difference, such as resident discharge, hospital leave, hospice, or death.</p> <p style="padding-left: 20px;">B. Total days billed: Agree medical and billing records. Ensure days billed equal care days</p>			

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Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Procedures covered in medical record and billing record.</p> <p>1. Differences: Make an inquiry; obtain existing support documentation and include adjustment on adjustment sheet with notation "documentation received" which may support difference. Unsupported differences are recorded as adjustments.</p> <p>C. Covered Medicare Part B Days for Medicaid residents : Agree to medical and billing record. Using medical record as guide for identifying needed services, ensure provider has billed Medicare appropriately, therapies and pharmaceuticals. Refer to Response (E) when performing the procedure. Seek the provider's assistance, when needed.</p> <p>1. Trace revenues earned to general ledger and ensure ledger accounts were posted to the appropriate Cost Report revenue accounts, Medicare Part B. Where general ledger accounts do not trace to Cost Report revenue accounts and cost report Schedule A-2 does not report an offset for Medicare nor cost report Schedule B-1, report offsets for Medicare. Refer the matter to the contract manager for further instruction.</p> <p>D. Resident medical record: Where MMIS report indicates, payment of hospital leave days, review</p>			

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Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Procedures</p> <p>hospital leave days, review hospital discharge notes to determine if skill care was recommended. When skill care recommended, trace to resident's billing. Ensure Medicare was billed for the appropriate days of service. Perform same procedure in 4 (C).</p> <p>5. Using either provider's billing, census, or medical records, haphazardly select the following number of residents by provider type:</p> <p style="margin-left: 20px;">A. NF – eight (8)</p> <p style="margin-left: 20px;">B. ICF-MR – two (2)</p> <p style="margin-left: 40px;">1. From the group selected in 5, select one (1) month of the resident's billings. Prepare work sheet using same format in Procedure 3. Perform the following:</p> <p style="margin-left: 60px;">a. Agree resident's billing to medical record and MMIS claims report for accuracy of reporting. Discuss with provider differences; obtain support documentation and include difference on adjustment sheet, with notation supporting documentation provided which may clear adjustment. Unsupported differences are adjustments to be included on adjustment sheet.</p> <p style="margin-left: 40px;">Ensure medical record supports services</p>			

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Program Based on Presumed or Anticipated Conditions			
Description	Indicate Program Changes	Working Paper Ref.	Time
<p>Procedures</p> <p>billed.</p> <p>2. Obtain support for resident liability and trace to MMIS claims report. Discuss with provider differences. Obtain support documentation for difference and include on adjustment sheet, with notation supporting documentation provided, which may clear adjustment. Unsupported differences are adjustments to be included on adjustment sheet.</p> <p>3. Where medical record identifies resident was discharged or died during period covered by MMIS claims report, ensure provider has not receive payment beyond date of discharge or death. If payment received, make an inquiry to obtain documentation return of overpayment. Include on adjustment sheet the overpayment with notation support documentation received from provider which may clear finding.</p> <p>6. Post Adjustments: Review procedures performed. Ensure all adjustments are posted to adjustment sheet with stated reason for adjustment. When necessary, contact the contract manager for assistance.</p> <p>7. Review and Supervisory Review Comments</p> <p>8. Clearing of Supervisory Review Comments.</p>			

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Section of Work **CASH DISBURSEMENTS TEST (CD)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Overview</u></p> <p>This program's objective is to determine the provider's system of internal control over cash is in place and operating effectively. The results of this program can be used to establish the scope of work performed in other areas.</p> <p><u>Procedures</u></p> <ol style="list-style-type: none"> 1. Select two months from the audit period. Months selected are _____ 2. Obtain voucher distribution register and test foot to account distribution totals. On a test basis tie account distribution to general ledger. 3. Foot account distribution totals to grand total and tie to general ledger accounts payable entry. 4. From the two monthly periods selected above, select 20 disbursements, excluding payroll expenditures and payroll taxes, for each month to vouch. Perform the following: <ol style="list-style-type: none"> a. Prepare a schedule with following column headings: <ul style="list-style-type: none"> • Voucher number • Vendor name • Vendor number • Invoice number • Invoice date • Invoice amount • Account distribution • Amount distributed by account • Description of expenditure 			

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Section of Work **CASH DISBURSEMENTS TEST (CD)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>Continued from 4: <u>Procedures</u></p> <ul style="list-style-type: none"> • Check number • Check date • Check amount <p>b. Agree appropriate data to voucher, invoice and distribution register.</p> <p>c. Note agreement of invoice and signed purchase.</p> <p>d. Note agreement of invoice and receiving report where applicable.</p> <p>e. Note that supporting documentation is properly canceled.</p> <p>f. Note indication of clerical accuracy test.</p> <p>g. Note proper approval to pay.</p> <p>h. Note propriety of account distribution.</p> <p>i. Ensure invoice amounts agree to amount paid.</p> <p>j. Tie check amount, number and date to canceled check.</p> <p>k. Note propriety of payee and first endorsement.</p> <p>5. Prepare Memo and Post Cost Adjustment(s) [PCAs] – prepare memo outlining procedures performed, procedures omitted or modified. Post PCAs to Proposed Cost Adjustment Sheet with brief narrative stating reason(s) and rule cited.</p>			

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Section of Work **CASH DISBURSEMENTS TEST (CD)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Procedures</u></p> <p>6. Review and supervision.</p> <p>7. Clear review points.</p>			

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Section of Work **PAYROLL TEST (PR)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>Overview</u></p> <p>Payroll expenses costs constitute a significant portion (in excess of 50%) of the provider's total operating cost. The overall objective of the payroll procedures are to assure salaries, wages and other payroll expenses are in compliance with Reimbursement Principles. In performing our examination, we will document the compensation paid to owners and relatives and ensure it has been disclosed and stated correctly on cost report schedules C-1 and C-2. and duties or functions performed are related to facility's operation. Our examination will support costs as being allowable, reasonable and related to resident care.</p> <p><u>Procedures</u></p> <p>1. Departmental/Payroll Account Analysis</p> <p>Have provider prepare Annual Departmental/Payroll Account analysis. Have provider include the payroll accruals and other related adjusting entries by account number. Trace totals from prepared schedule to trial balance. Review and obtain explanation for any unusual variations or adjusting entries. Material differences, 5% of or greater of total payroll are adjusted, if unexplained and lacking adequate documentation.</p> <p>2. Examine total payroll expenditures by account number for current period. Compare current period to prior period using Risk/Cost Analysis and obtain explanations for significant variations. When comparing by account number, consideration should be given for material differences within each Cost Center (Other Protected</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continued from 2 <u>Procedures</u></p> <p>Care, Direct Care & Indirect Care). Explanations should be obtained for differences in excess of amounts on <u>Attachment 1</u>.</p> <p>3. Select one pay period from payroll register. Trace amounts by account number to general posting and to Annual Departmental Account Analysis. Randomly test foot payroll register and general ledger.</p> <p>4. Obtain copies of the provider's payroll tax statements for FICA, FUTA, SUTA and Worker's Compensation. Trace totals (payroll) from documents to prepared payroll summary in step 1 and trial balance. Determine reasonableness of payroll tax distribution for Other Protected, Direct and Indirect Care Costs. Obtain explanations for material differences. Material difference are amounts equal to or greater than 5% of total taxes.</p> <p>5. For month selected in Step 3 above, select a representative sample of employees for one pay period from the detail in step 1 and prepare a schedule listing the following data:</p> <p>a . Employee number</p> <p>b. Employee name</p> <p>c. Regular hours worked</p> <p>d. Overtime hours worked</p> <p>e. Department, cost center or account charged</p>			

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Section of Work **PAYROLL TEST (PR)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continued from 5: <u>Procedures</u></p> <p>f. Amount charged</p> <p>g. Job description</p> <p>h. Pay rate</p> <p>i. Gross pay</p> <p>j. Net pay</p> <p>6. Perform following on schedule obtained in Step 5 above.</p> <p>a. Verify employee number, pay rate and job description by reference to personnel files.</p> <p>b. Tie hours worked to time cards and job schedules.</p> <p>c. Verify distribution of charges by reference to time cards and job schedules. Ensure distribution is reasonable based on job description.</p> <p>d. Recompute amounts distributed and gross pay.</p> <p>e. Tie distribution to distribution journal and gross and net pay to payroll register.</p> <p>f. Personally meet all selected employees and require identification if presently employed by the providers. Review employee personnel file, noting their hire date, termination date, department worked. If not employed, ensure the employee does not appear in the pay period subsequent to his termination date.</p>			

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Section of Work **PAYROLL TEST (PR)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continued from 6: <u>Procedures</u></p> <p>following data:</p> <ul style="list-style-type: none"> • Interview employees to ascertain their actual job duties agree with the reporting category expensed. Determine if information is consistent with position description and hours worked maintained by provider. Document interview in your workpapers, noting date, time, and type of employee identification (e.g., driver's license, etc.) examined. <p>7. Examine the W-2s and other payroll documents for employees related to owners and owners and their compensation, which has not been disclosed on either cost report schedule C-1 or C-2. If not disclosed, determine whether or not the compensation was included in allowable cost. If included in allowable cost, determine whether or not the service rendered was related to resident care. If compensation amounts are included in allowable cost, but not disclosed on schedules C-1 or C-2; prepare the appropriate revised schedule identifying individual, social security number, account number (must have wage component), employment dates within reporting period, hours worked weekly based on 40 hour work per week in facility and compensation paid. Duties not related to resident; disallow the reported compensation.</p> <p>8. Discuss the following items related to payroll costs of owners, relatives, related to stockholders or owners, with management and write a memo, indicating the</p>			

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Section of Work **PAYROLL TEST (PR)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>continued from 8: <u>Procedures</u> person with whom discussions were held:</p> <p>a. Are there employees who are stockholders or owners or related to stockholders or owners earning compensation that is reported as allowable cost? What are the services performed, their job position, and compensation earned (W-2)? Trace this information to Schedules C-1 and C-2 of the cost report, noting agreement.</p> <p>b. Are there any employees who perform services that are not related to the delivery of health care and their position and compensation.</p> <p>Where necessary adjust from allowable cost compensation paid for services for related to resident care and when needed prepare amended Schedules C-1 and C-21 to include omitted persons or compensation.</p> <p>9. Verify the accuracy of information (hours worked, work period and compensation) as reported on Schedule C-1 of the Cost Report for Administrators.</p> <p>10. Prepare Memo and Post Cost Adjustment(s) [PCAs] Prepare memo outlining procedures performed, procedures omitted or modified. Post PCAs to Proposed Cost Adjustment Sheet with brief narrative stating reason(s) and rule cited.</p> <p>11. Review and supervision.</p> <p>12. Clear review points.</p>			

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Section of Work **OWNERS'S EQUITY (OE)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><i><u>For Non Profit Providers</u>, except where transaction may affect filed cost, pass on the program procedures.</i></p>			
<p><u>Overview</u></p> <p>The purpose our review of equity is to provide reasonable assurance equity has been reported in accordance with Reimbursement Principles and generally accepted accounting principles. In performing our review, we should be alert for transactions related to contributions, donations or other receipts not allowable or which should be treated as cost reductions or accounts which are not used in providing resident care. Testing of Equity can be passed for nonprofit providers, since they are not entitled to return on equity reimbursement. Testing of Equity can be passed upon for profit providers having zero or negative equity, since no reimbursement is received. Caution should be exercised when passing, since Equity may affect reported expenditures. If passed, write a memo explaining reasons</p>			
<p><u>Procedures</u></p> <ol style="list-style-type: none"> 1. Cost Report Schedule E-1, page 1 of 2 - Review and document equity transactions or accounts not accounted for in accordance with Medicaid's Hierarchy of Rules. <ol style="list-style-type: none"> a. Loans Due or From Owners/Officers b. Assets Leased from Related Party c. Home Office Equity <p>Obtain provider's documentation for Home Office Equity Adjustment (trial balances and allocation methodology) and ensure only allowable accounts have been included and method of allocating home office</p>			

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Section of Work **OWNERS's EQUITY (OE)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><i>For Non Profit Providers</i>, except where transaction may affect filed cost, pass on the program procedures.</p> <p><u>continued from 1:</u> <u>Procedure</u></p> <p>equity is reasonable, pursuant to CMS Pub. 15 Section 2150. Any non allowable account or change in allocation basis will require a re-allocation of home office equity and subsequent PCA</p> <p>2. Obtain a listing of all stockholders, for entities not publicly traded, partners, etc. Review stock certificate books and account for the number of outstanding shares, as well as amount recorded for capital stock. Review corporate charter articles of incorporation or partnership agreement, as appropriate. Review for the identification of owners and relatives claiming remuneration not reported on C-2.</p> <p>3. Do the same as (2) above for all preferred stock, as well as partnership accounts, as appropriate.</p> <p>4. Recomputed provider's allowable equity investment in the health care facility. Exclude from calculation all assets or liabilities not related to resident care as indicated by Reimbursement Principles.</p> <p>5. Prepare Memo and Post Cost Adjustment(s) [PCAs]</p> <p>Prepare memo outlining procedures performed, procedures omitted or modified. Post PCAs to Proposed Cost Adjustment Sheet with brief narrative stating reason(s) and rule cited. When posting adjustments to schedule E-1, page 1 of 2, denote account and whether adjustment affects the beginning balance with 1 or ending balance</p>			

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Section of Work **OWNERS's EQUITY (OE)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><i>For Non Profit Providers</i>, except where transaction may affect filed cost, pass on the program procedures.</p> <p><u>continued from 5:</u> <u>Procedure</u></p> <p>with 2. Also, include Revised Equity Memo as part of your report with rules cited and brief narrative explaining reason for adjustment.</p> <p>6. Review and supervision.</p> <p>7. Clear review points.</p>			

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Section of Work **RESIDENT PERSONAL ALLOWANCE FUNDS (PNA)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>Fiduciary Responsibilities</p> <p><u>Overview</u></p> <p>Pursuant to Rules 5101:3-3-60 and 5101:3-3-93 of the OAC Residents of NFs or ICFs-MR Each month, each Medicaid resident who receives care in a certified Medicaid facility is entitled to retain a Personal Allowance Account (PNA) in the amount set forth in rule <u>5101:1-39-22.3</u> of the Administrative Code for the purchase of items and services of his or her choice. This PNA is the exclusive property of the resident to use as he or she chooses to meet his or her personal needs.</p> <p>Procedures</p> <ol style="list-style-type: none"> 1. Have the provider complete the Personal Allowance Account Questionnaire. 2. Haphazardly, select five 5(five) Medicaid PNA and document provider's compliance with Rules 5101:3-3-60 for NFs and 5101:3-3-93 for ICFs-MR of the OAC. Prepare a workpaper documentation the provider's compliance with following: <ol style="list-style-type: none"> a. Resident's Personal Account (PNA)(s) – are not commingled (distinct bank accounts) with facility's funds. b. Individual PNA – in excess of \$50 are deposited in an interest bearing account, within five (5) banking days from date funds exceed \$50. 			

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Section of Work **RESIDENT PERSONAL ALLOWANCE FUNDS (PNA)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>Fiduciary Responsibilities</p> <p>continuation of 2: <u>Procedure</u></p> <p>c. Withdraws – are acknowledged by resident’ signature, if capable or X if not and verified through signature of two (2) witnesses.</p> <p>d. Accounting records maintained must identify specific dates for and reasons for expenditures and receipts available upon request.</p> <p>e. Expenditures are appropriate pursuant to (L) and (M of Rule 5101:3-3-60 for NFs and (P) and (0) of Rule 5101:3-3-93 of the OAC for ICFs-MR.</p> <p>f. PNA equaling \$1,500</p> <p style="padding-left: 40px;">Document that the provider has given the County Department for Job and Family Service notice that the resident’s personal allowance account balance is \$1,500 or greater.</p> <p>g. Fees</p> <p style="padding-left: 40px;">Provider does not charge a fee for managing PNAs.</p> <p>h. Conveyance upon death</p> <p style="padding-left: 40px;">Assure provider has adhered to Procedures prescribed in OAC Rules 5101:3-3-60 (H) and 5101:3-3-93 (H).</p> <p>3. Prepare Memo outlining procedures performed, procedures omitted or modified. Where provider is found</p>			

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Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p>Fiduciary Responsibilities</p> <p><u>continuation of 3:</u></p> <p><u>Procedure</u></p> <p>circumstance, approximate date of occurrence in memo and send to contract manager. Include same information in other comments section of audit report for Personal Allowance.</p> <p>4. Review and supervision.</p> <p>5. Clear review points.</p>			

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Section of Work **WRAP-UP/EXIT CONFERENCE (WP)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<u>Procedure</u>			
<p>1. Summarize the Proposed Cost Adjustment (PCAs) in the following manner:</p> <p style="padding-left: 20px;">a. Prepare and maintain a Proposed Cost Adjustment (PCA) schedule. This schedule should be formatted so as to facilitate tracking of inter-period effect of adjustments proposed. Adequate explanation of each adjustment should be indicated, including references to authoritative support. Adjusting entries should be reviewed on a timely basis with the provider. Note, consider the Monetary Finding Amount needed to make a one cent change in the provider's reimbursement rate. When proposing cost adjustments (PCAs), keep in mind, the amount needed to effect the rate. Cumulative adjustments by Cost Center, which are less than the amount needed to the change the rate may be excluded from the Summary of PCAs. If omitted from the Summary of PCAs, for reason of the amount being less than the Monetary Finding Amount, document the omission on the Summary of PCAs.</p> <p>2. Conduct an exit conference with provider management to review the proposed adjustments. Note agreement or disagreement with proposed adjustments and record other pertinent comments. Have the provider sign the proposed adjustments schedule.</p> <p>3. Representative Questionnaire</p> <p>Have provider review and make appropriate notations to questions asked and then sign. Review for any comments or notations which might have significant bearing on the</p>			

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES
Office of Research, Assessment and Accountability
Bureau of Audit

AUDIT WORK PROGRAM - Full Scope

Provider Name _____

Provider Number _____

Cost Report Period _____

Audit Date _____

Section of Work **WRAP-UP/EXIT CONFERENCE (WP)**

Program Based on Presumed or Anticipated Conditions	Work Completed		
Description	WORKING PAPER REF.	BY	TIME
<p><u>continuation of 3:</u> <u>Procedure</u></p> <p>audit. If you believe significant events have occurred, which were not captured by the audit procedures completed, contact the contract administrator for guidance. Additional audit procedures may be warranted.</p> <p>Review Audit Working Papers</p> <p>4. Review Audit Working Papers</p> <p>Ensure sufficient competent evidential matter was ascertained. All audit findings are to be properly documented in the audit work papers. Documentation should contain the rule or law upon which reliance is being made to support the finding. Each finding should be communicated to the provider or his representative. Document the date, time, name and title of individual to whom findings were communicated.</p> <p>5. Prepare the final audit report documents, Audit Input document 1, PCA Sheets, Equity Memo, and Other Support Documents, along the established guidelines of the Department of Job and Family Services.</p> <p>6. Review and supervision</p> <p>7. Clear review points.</p>			