

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

AUDIT WORK PROGRAM - **LIMITED SCOPE**

Provider \_\_\_\_\_  
Name \_\_\_\_\_  
Cost Report Period \_\_\_\_\_

Provider \_\_\_\_\_  
Number \_\_\_\_\_  
Audit Date \_\_\_\_\_

**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 **limited or full scope**, 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 **limited or full scope 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 **limited or full scope 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 Job 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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**OVERVIEW**

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

**Work papers** should include the name of the provider, 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 (reference the rule within the 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 a 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. 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 and competent evidential matter.

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**OVERVIEW** (CONT)

**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 notes, which may be worth mentioning in the audit report to advise the provider of potential problems, although it may not have a fiscal affect in the current year. It is the responsibility of the auditor to ensure the audit report is complete and accurate.

**Reference Material** required for the completion of the cost reports must be in conformance with Ohio Medicaid rules and regulations. These regulations should be applied in the following order:

**Medicaid's Hierarchy of References**

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 (HCFA Pub. 15-1), a.k.a., Health Insurance Manual 15 (HIM-15)**
5. **Generally Accepted Accounting Principles**

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Provider Name \_\_\_\_\_ Provider Number \_\_\_\_\_  
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Program Based on Presumed or Anticipated Conditions	Work Completed		
<p style="text-align: center;"><b><u>Overview</u></b></p> <p>Provides an administrative checklist for auditor for completion of audit by performing the Procedures identified. For Procedures omitted or modified prepare a memo which explains modification or reason(s) for the omission.</p> <p style="text-align: center;"><b><u>General Procedures</u></b></p> <p>1. Obtain from ODJFS the cost report for the period under audit. Tie (reconcile) cost report to provider's working trial balance. Request from the provider a copy of the general ledger. Tie general ledger to trial balance. Obtain explanations and supporting documentation for any <b>*material differences</b>. Any undocumented material difference reported as an allowable cost is adjusted (Proposed Cost Adjustments (PCAs)) from provider's reported allowable cost.</p> <p>2. In reconciling the cost report to the trial balance, review for the proper reporting of cost pursuant to the 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 of OAC.</p> <p>2. 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 Manager for a copy of 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 differently, make the necessary proposed cost adjustments to agree with LTC's letter.</p>	WORKING PAPER REF	BY	TIME

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<p>4. When selecting accounts for examination, review audit risk, rate setting, prior audit work papers and, if available, the provider’s Medicare Cost Report and Audit Report and consider the following:</p> <ul style="list-style-type: none"> <li>a. Audit History - review audit reports for findings which may affect the current period.</li> <li>b. Final Settlement History – denoted on last page of provider’s audit risk analysis, which tracks provider’s audits of the last 5 years and the proposed cost adjustments (PCAs).</li> <li>c. Monetary finding - amount needed to make a one cent change in the provider’s reimbursement rate by cost center.</li> <li>d. Medicare Adjustments/Findings- examine Medicare’s audit report for adjustments/findings. Include adjusted cost/accounts in test selections when applicable to ensure similar costs are included in provider’s Medicaid cost report.</li> </ul> <p style="text-align: center;"><b><u>Complete a memo documenting your observations.</u></b></p> <p>5. Amend the work program as needed. Document the reasons for omitted or modified Programs or Procedures.</p> <p>6. Contact the provider and make the necessary arrangements regarding timing of audit, and needed documentation Confirm your request in writing with letter, (Audit Engagement Letter and Attachments) sent certified mail, with return receipt requested. For provider’s response, allow two (2) to three (3) weeks to provide information requested.</p> <p>7. Review and Supervision.</p> <p>8. Clear review points.</p>			
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<p style="text-align: center;"><b><u>Overview –Assets Work Program</u></b></p> <p>The profit providers may be reimbursed a Return on Equity. The maximum reimbursement for Return on Equity is \$1.00 per day for ICFs –MRs and \$.50 per day for NFs. Testing can be on passed for nonprofit and profit providers having zero or negative Return on Equity, since no reimbursement is received. See cost report schedule E-1 page 1 of 2. Caution should be exercised when passing, since Assets and Liabilities affect reported expenditures. <b><u>If passed</u></b>, write a memo explaining reason(s). <b><u>For profit providers</u></b> receiving a Return on Equity, it will be necessary to complete the applicable procedures of Assets, Liabilities and Equity.</p> <p style="text-align: center;"><b><u>Asset Procedures</u></b></p> <ol style="list-style-type: none"> <li>1. Examine the Asset Trial Balance for following:       <ol style="list-style-type: none"> <li>a. Material change in Account Balances – comparing beginning balance to ending balance. The difference between beginning and ending account balance, if difference is greater than 25% of beginning account balance 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 Regulations. Any material change not adequately documented is adjusted from the provider’s allowable equity as unsupported cost, pursuant to CMS-Publication 15-1, Section 2304. Omit this procedure, when provider has reported no beginning account balances.</li> <li>b. Review Cash Balances – for excess cash on hand not used in providing resident care pursuant to CMS Publication 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 operation expenses , then the amount in excess is disallowed from provider’s allowable equity, pursuant to CMS Publication 15-1, Section 1218.2. Total operating expenses include both allowable and non allowable expenses for this determination.</li> </ol> </li> </ol>			
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<p>2. Examine the Provider’s Trial Balance in conjunction with CMS Publication 15-1 Chapter 12 to determine allowability of reported accounts. In general, any asset or liability not related to providing resident care is excluded from provider’s allowable equity determination, pursuant to CMS Pub. 15-1 Section 1218.1. Scan Trial Balance for following accounts:</p> <p>a. <u>Investment Accounts</u> – any investment account not readily converted to cash is disallowed in computing provider’s allowable equity, pursuant to CMS Pub. 15-1, Section 1218.2.</p> <p>b. <u>Contingencies/Cost Settlements</u> – if reported, determine their allowability, pursuant to Chapter 12 of CMS Pub. 15-1.</p> <p>c. <u>Intangible Accounts</u> –</p> <ul style="list-style-type: none"> <li>• Non-Competitive Agreements – Non-allowable pursuant to CMS Pub. 15-1, Section 1218.7.</li> <li>• Goodwill – Non-allowable pursuant to CMS Pub. 15-1, Section 1214.</li> <li>• Certificate of Need – allowable pursuant to OAC Rule 5101:3-3-51.6 (G)(3) for NFs and OAC Rule 5101:3-3-84.5 (G) for ICFs-MR.</li> </ul> <p>3. Other accounts – determined the allowability pursuant to CMS Publication 15-1 Chapter 12</p> <ul style="list-style-type: none"> <li>a. Construction in Process -</li> <li>b. Cash Surrender Value of Life Insurance</li> <li>c. Prepaid Life Insurance Premiums</li> <li>d. Self-insurance Reserve Fund</li> </ul> <p>4. Prepare a Memo summarizing your observations and findings. Post your adjustments to the PCA Sheet(s).</p> <p>5. Supervisory Review</p> <p>6. Clear review points</p>			
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<p style="text-align: center;"><b><u>Overview - Liabilities Work Program</u></b></p> <p>The profit providers may be reimbursed a Return on Equity. The maximum reimbursement for Return on Equity is \$1.00 per day for ICFs –MRs and \$.50 per day for NFs. Testing can be on passed for nonprofit and profit providers having zero or negative Return on Equity, since no reimbursement is received. See cost report schedule E-1 page 1 of 2. Caution should be exercised when passing, since Assets and Liabilities affect reported expenditures. <b><u>If passed</u></b>, write a memo explaining reason(s). <b><u>For profit providers</u></b> receiving a Return on Equity, it will be necessary to complete the applicable procedures of Assets, Liabilities and Equity.</p> <p style="text-align: center;"><b><u>Liabilities Procedures</u></b></p> <ol style="list-style-type: none"> <li>1. Review all mortgages and notes payable for which interest expense has been reported. Detail the amount of the loan, interest rate, date of loan, lender and purpose of loan and tie interest expense and loan balance to the trial balance. Ensure any loans between related parties or organizations are properly treated pursuant to CMS Publication 15-1, Chapter 12. An exception will apply for Related Party Loans, where provider can document his inability to obtain conventional financing, where owner has personally obtained financing from a commercial lender. The reported loan and interest expense is allowable, if supported by an agreement from an unrelated lending institution and the purpose is related to resident care</li> <li>2. Examine other liability accounts, for compliance with Chapter 12 of CMS Pub. 15-1. If non allowable accounts are reported in provider's allowable equity, disallow them from the calculation. Also, ensure the expenditure for the disallowed account has been removed from allowable cost. If not, adjust the expense to agree with Medicaid's Rules and Regulations.</li> <li>3. Prepare a Memo summarizing your observations and findings. Post your adjustments to the PCA Sheet(s).</li> <li>4. Supervisory Review</li> <li>5. Clear review points</li> </ol>			
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<p style="text-align: center;"><b><u>Overview - Owner's Equity Work Program</u></b></p> <p>The profit providers may be reimbursed a Return on Equity. The maximum reimbursement for Return on Equity is \$1.00 per day for ICFs –MRs and \$.50 per day for NFs. Testing can be on passed for nonprofit and profit providers having zero or negative Return on Equity, since no reimbursement is received. See cost report schedule E-1 page 1 of 2. Caution should be exercised when passing, since Assets and Liabilities affect reported expenditures. <b><u>If passed</u></b>, write a memo explaining reason(s). <b><u>For profit providers</u></b> receiving a Return on Equity, it will be necessary to complete the applicable procedures of Assets, Liabilities and Equity.</p> <p style="text-align: center;"><b><u>Equity Procedures</u></b></p> <ol style="list-style-type: none"> <li>1. Reexamine provider's allowable equity - using cost report schedule E-1, page 1 of 2, to determine the provider's allowable equity. Ensure allowable equity includes only transactions that are in accordance with CMS Pub. 15-1, Chapter 12.             <ol style="list-style-type: none"> <li>a. Loans Due or From Owners/Officers –</li> <li>b. Assets Leased from Related Party – document the allowable assets and liabilities and recomputed allowable equity in the transaction.</li> <li>c. Home Office Equity – obtain the provider's documentation for the Home Office Equity Adjustment (trial balances and allocation methodology) ensure only allowable accounts have been included in the allowable home office equity and that the provider's method of allocating home office equity is reasonable, pursuant to CMS Pub-15-1, Section 2150. Any accounts determined not related to resident care or change in allocation basis will require a re-allocation of the home office and subsequent proposed cost adjustments (PCAs).</li> </ol> </li> </ol>			
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<p>2. Prepare memo summarizing the results of Procedure 1. Post your adjustments to the PCA Sheet(s).</p> <p>3. Review and Supervision</p> <p>4. Clear Review Points.</p>			
<b><u>Overview- Property Work Program</u></b>			
<p>The work performed verifies following:</p> <p>A. Historical Cost of Acquired Assets – existence and agreement to provider’s source documentation.</p> <p>B. Depreciation expense - is reported on a straight line 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 OAC. <b><u>For newly acquired assets in the month that a capital asset is placed into service, no depreciation expense is recognized as an allowable expense.</u></b> A full month's depreciation expense is recognized in the month following the month the asset is placed into service, pursuant to Rules 5101:3-3-51.1 and 5101:3-3-84.1 of the OAC.</p> <p>C. Leases are reviewed for Transactions between Related Parties, pursuant to Rule 5101:3-3-01 (BB) of the OAC for both provider types and compliance with</p>			

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<p>Rule 5101:3-3-51.5 of the OAC for NFs.</p> <p>D. Depreciation Expense – is recognized for depreciable assets used in providing resident care.</p> <p style="text-align: center;"><b><u>Property Procedures</u></b></p> <p>1. Obtain a copy of the provider’s listing of Fixed Depreciable Assets and clerically test and tie to Trial Balance and General Ledger. Any difference, that is greater than 5% of total depreciable assets reported; the provider must document the difference. <i>If undocumented, adjust the difference as unsupported cost, pursuant to CMS Pub. 15-1, Section 2304.</i></p> <p>2. Examine useful lives for compliance and recompute depreciation expense on a test basis. Seek an explanation for any differences noted. If explanation given does not agree with appropriate rules, adjust reported cost accordingly.</p> <p>3. Review the listing for any assets having the appearance of being not related to resident care or reimbursed by another program (see procedure 4 for treatment). Discuss with provider your observations. Prepare a memo of your discussion and the provider’s comments. If non allowable assets are reported, ensure adjustments have been made to exclude the associated costs (depreciation and interest expense) from the provider’s allowable cost.</p>			
<p>4. Document on a test basis any additions since the last period audited. Select at least ten (10) additions for each calendar year to document, using highest dollar amount for selection criteria. Of items selected, prepare a work paper documenting following:</p> <ul style="list-style-type: none"> <li>• Check number</li> <li>• Payee</li> <li>• Check Date</li> <li>• Check Amount</li> <li>• Invoice Amount</li> <li>• Invoice Date</li> </ul> <p><b><u>Test for following Attributes:</u></b></p> <ul style="list-style-type: none"> <li>• Useful life established complies with appropriate rules.</li> </ul>			

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<ul style="list-style-type: none"> <li>• Depreciation Expense was computed properly</li> <li>• Addition is related to resident care</li> <li>• Not financed by another governmental agency. If financed, where there is no obligation to pay, then the cost is appropriately removed from allowable expenses, pursuant to Rule 5101:3-3-51.2(A)(1)(e) for NF and Rule 5101:3-3-84.2(A)(1)(e) for IMRs.</li> </ul> <p>5. Examine Leases for transactions between Related Parties pursuant to Rule 5101:3-3-01 (BB) of the OAC and compliance with Rule 5101:3-3-51.5 of the OAC. Pursuant to Rule 5101:3-3-01(BB) of the OAC the sale of facility to related party is allowable, if all of the following conditions apply:</p> <ul style="list-style-type: none"> <li>• Provider/prior owner making transfer does not have a direct or indirect interest in the acquiring provider or its operations as:             <ul style="list-style-type: none"> <li>a. Owner</li> <li>b. Officer</li> <li>c. Director</li> <li>d. Employee</li> <li>e. Independent Contractor</li> <li>f. Consultant</li> </ul> </li> </ul> <p>The only interest the prior provider may have in the acquiring provider's operations is that of a creditor. If any of the above apply, reported cost is adjusted to what the prior provider would have reported, pursuant to OAC Rule 5101:3-3-01 (BB).</p> <p>6. For providers (NFs only) who have filed cost in the following account numbers:</p> <ul style="list-style-type: none"> <li>a. 8110 Depreciation - Building</li> <li>b. 8140 Depreciation - Equipment</li> <li>c. 8170 Interest - Property, Plant and Equipment</li> <li>d. 8195 Lease Expense</li> </ul>			
<p>6. <b>Continuation of Procedure 6</b> - Obtain from Contract Manager, Long Term Care's (LTC) valuation for assets acquired through a Change in Provider Agreement. Trace allowable cost from LTC's Letter to provider's depreciation schedule. Differences not in accordance with LTC's Letter, if reported as allowable cost, are disallowed.</p> <p>7. For providers having additions to Renovations, Account Number 1300, acquired subsequent to December 31, 1993, obtain from the Provider LTC's Nonextensive Renovation Approval Letter. Trace information from</p>			

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<p>approval letter to depreciation schedule. Amounts exceeding the greater of ten (10) percent or twenty thousand dollars (\$20,000) for NFs or two thousand dollars (\$2,000) for ICFs-MR of first approval will require a second approval from LTC. Obtain from provider a copy of second approval letter and trace the approved amount to difference. The amounts in excess of the approval or amounts requiring LTC's approval, where approval was not sought, are reclassified to cost of ownership, if documented as being allowable, reasonable and related to resident care. If financed, the associated interest expense is reclassified to cost of ownership, also. If the provider is unable to provide a copy of LTC's approval letter, contact Contract Manager for copy. Where the provider is unable to provide and the Contract Manager is unable to confirm LTC's approval and the cost are documented as allowable and reasonable; reclassify the reported costs to the appropriate 8000 account number.</p> <p>8. Lease Expense – Account Number 8060 – obtain a copy of provider's lease agreement and document allowability of the reported costs by ensuring the agreement is not between related parties, except where (BB) of Rule 5101:3-3-01 applies. Ensure amount reported agrees with the agreement and was paid.</p> <p>9. Transportation Expenses – Leases and Depreciation expense – ensure that reported expenses are allowable and reasonable. Luxury vehicles and vehicles used solely by owners and corporate officers are adjusted from allowable cost pursuant to CMS Pub.15-1, Section 2102.3.</p> <p>10. Prepare a memo summarizing the results of the completed procedures and findings. Post your adjustments to Proposed Cost Adjustments Sheet.</p> <p>11. Review and Supervision</p> <p>12. Clear review points.</p>			
<p><b><u>Overview - Census Work Program</u></b></p> <p>The accuracy of the provider's reported Total Inpatient Days is essential in calculating the provider's reimbursement's rate. The following procedures are designed to verify the accuracy of reported Total Inpatient Days.</p>			

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<u>Census Procedures</u>			
<p>1. Compare Total Inpatient Days of the current reporting period to Total Inpatient Days of the prior period, using the information found on Risk/Cost Analysis. Be sure the number of months in each period is equal. If months in reporting are unequal go to procedure 2. If difference between current and prior reporting period is greater than of 5% of total inpatient days of the prior reporting period or 2,000 days for NFs and 500 days for IMRs; have provider prepare a statement explaining reasons for difference.</p> <p>2. Obtain a copy of provider’s daily census logs and tie to Cost Report Schedule A-1, column 9, line 13, Total Inpatient Days. Any difference should be documented by provider. Unexplained differences greater than .01% of total inpatient days or 3 days are adjusted as unsupported data, pursuant to CMS 15-1, Section 2304. Authorized NF leave days, Hospital and Therapeutic Leave Days for Medicaid residents, are included in count of Total Inpatient days at 50%, while authorized leave days for ICFs-MR Medicaid Residents are included in the count of Total Inpatient Days at 100%. Leave days for all other resident types are not counted as an inpatient day as well as bed hold days (reserving a bed).</p>			
<p>3. Data Supplied by the Contract Manager – there will be circumstances where provider’s MMIS Medicaid days (days paid by ODJFS) are in excess of provider’s reported Total Inpatient Days. The Contract Manager will provide a report summarizing the provider’s paid MMIS Medicaid days. Where MMIS Medicaid Days exceed Total Bed Days Available or Inpatient Days, have the provider reconcile the difference. Obtain from provider documentation supporting the reconciling difference. Forward copies of provider’s memo and support documentation with cover letter to Contract Manager.</p> <p>4. Prepare a memo summarizing the results of the completed procedures and findings. Post your adjustments to the Proposed Cost Adjustments Sheet (PCAs). For account number, when posting adjustments to PCAs, use “A113” as the account number. When posting</p>			

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adjustments for procedure 2 and the provider has not provided adequate documentation supporting difference; reductions in Total Inpatient Days are not posted as an adjustment.			
5. Review and supervision.			
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<p style="text-align: center;"><b><u>Overview – Payroll Work Program</u></b></p> <p>Payroll expenditures, salaries, taxes and fringe benefits, represent more than 50% of the provider’s reported allowable cost. Reported salaries, wages and other payroll expenses are reviewed to determine following:</p> <ul style="list-style-type: none"> <li>• To ensure reported cost are allowable, reasonable and related to resident care.</li> <li>• To ensure related payroll costs, salaries, taxes and benefits have been properly classified /allocated, pursuant to Chart of Accounts, Appendix A, OAC Rule 5101:3-3-20.1.</li> <li>• To ensure Owners/Corporate Officers Compensation is properly classified, allowable and is disclosed on the applicable cost report schedules C-1 or C-2.</li> </ul> <p style="text-align: center;"><b><u>Payroll Procedures</u></b></p> <p>1. Review payroll expenditures for period by account number and compare to the prior period, using the Risk/Cost Analysis. When comparing by account number, consideration should be given for material differences within each Cost Center (Other Protected Care, Direct Care &amp; Indirect Care). An explanation and documentation should be obtained from provider for Payroll Cost Center Differences which exceed (Increase/Decrease) following:</p> <p><b><u>NFs</u></b>  <i>Direct Care Cost Center 14% or \$376,653</i>  <i>Indirect Care Cost Center 11% or \$120,240</i></p> <p><b><u>ICFs-MR</u></b>  <i>Direct Care Cost Center 15% or \$91,1007</i>  <i>Indirect Care Cost Center 7% or \$12,650</i></p> <p>2. Request provider to prepare an Annual Payroll Departmental Analysis, which includes payroll accruals and other payroll related adjusting journal entries. Request copies of payroll tax statements (941s, 940s, and SUTA) and Worker’s Compensation Statements for period.</p> <p>3. Tie Payroll Departmental Analysis prepared by provider to Trial Balance. Obtain an explanation and documentation for any differences greater than 5% of the total cost reported by cost center. Obtain an explanation and documentation for any differences greater than 5% of the total cost reported by</p>			
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<p>cost center. Any undocumented differences, if reported as allowable cost, are adjusted from allowable cost. <b>(Note: Possible differences experienced in comparing cash basis to the 941s may be due to 125 Cafeteria plans, sick and disability plans, IRS compensation for auto use, and bonuses paid).</b></p>			
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<p>4. Reconcile Cash Basis Payroll from Departmental Analysis to 941s, 940s, SUTA, and Worker’s Compensation statements. Tie payroll taxes and worker’s compensation expense from statements to Trial Balance of Expenses. Obtain an explanation and documentation supporting differences greater than 5% of total cost reported. Ensure that any applicable credits, refunds or rebates have been reported properly pursuant to Section 804 of CMS Publication 15-1. Document taxes have been paid. Make inquiry of method used to distribute taxes to various accounts contained within cost report and determine appropriateness of method; adjust accordingly.</p> <p>5. Tie payroll accruals (wages and taxes) to Trial Balance of Liabilities. Obtain an explanation and documentation for any difference greater than 5% of accrued expense. Undocumented difference greater than 5% of accrued expense, included as allowable cost, is adjusted from allowable cost as supported cost data.</p> <p>6. Verify accuracy of reported beginning and ending payroll accruals by re-computing. Any difference greater than 5% of accrued expense will need an explanation. Any difference unexplained, if greater than 5% of accrued expense is adjusted from allowable cost as unsupported cost data.</p> <p>7. Discuss with provider compensation earned by owners/officers or persons related to owners/officers, duties performed and reported cost category. Prepare a memo documenting discussion. Duties not related to resident care, where compensation is paid and claimed as allowable cost is removed from reported cost as cost not related to resident care pursuant to CMS Publication 15-1, Section 2102.3. Ensure reported compensation is reported correctly pursuant to Appendix A of Rule 5101:3-3-20.1 of the OAC, Chart of Accounts.</p>			
<p>8. Document for each person appearing on cost report schedules C-1 and C-2 by performing following:</p> <p>a. Prepare a work sheet identifying person,</p> <p>b. Social Security Number – trace to personnel file</p> <p>c. Begin and End dates of employment during reporting period – trace to</p>			

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<p>personnel file</p> <p>d. Hours Worked Weekly – recomputed, using wage rate from personnel file as divisor and divide into amount claimed.</p> <p>e. Account Number – trace to personnel file job description and duties to ensure agreement with reported classification.</p> <p>f. Amount Claimed – trace to W-2</p> <p>For any items not agreeing, ask provider for an explanation and documentation supporting the differences. Any unsupported differences are adjusted from reported expenses, where C-1 or C-2 may be affected; prepare revised schedules, also.</p> <p>9. Review and Supervision</p> <p>10. Clear review points</p>			
<p style="text-align: center;"><b><u>Overview – Expenditures Other than Payroll Related Expenses</u></b></p> <p>The overall objective is to determined following:</p> <ul style="list-style-type: none"> <li>• To determine that only allowable items of cost applicable to resident care have been included in reimbursable expenses pursuant to Rule 5101:3-3-01 (A) of the OAC.</li> <li>• To ascertain that records supporting statistical data and the adequacy of methods used for accumulating data are sufficient to properly develop valid and accurate statistical information.</li> <li>• To determine that goods and services acquired from related entities are reported at proper amounts pursuant to Rule 5101:3-3-01 (BB) (4).</li> <li>• To determine that all applicable credits, rebates or refunds have been properly offset, pursuant to Sections 804 and 2302.5 of CMS Publication 15-1.</li> </ul> <p><b>Account selections will be based on the following criteria:</b></p> <p>A. Accounts having a high risk for miss-reported cost.</p> <p>B. Prior audit findings where current period account is reviewed to ascertain if the provider has corrected the reporting error.</p>			

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<p>C. Risk/Cost Analysis, where material fluctuations exist between periods.</p> <p style="text-align: center;"><b><u>Procedures</u></b></p> <p><b>1.</b> Review the trial balance considering materiality. Eliminate immaterial accounts from the review. <b>Material accounts are defined as representing five (5) percent (%) or more of the total expenses per cost center, excluding payroll expenses; taxes and fringe benefits.</b></p> <p><b>2.</b> When performing substantiate tests, <i>expense accounts are haphazardly sampled, selecting at least fifty (50) percent of the account's disbursements.</i></p> <p><b>I. Nursing Facilities (NFs) - Parameters Determined by Cost Centers for Testing of Expenditures</b></p> <p><b>A. <u>Other Protected Costs</u></b> - Select at least three (3) accounts in Other Protected Care Cost Center, <b>which are not examined through other Work Program Procedures</b>, using Parameters 1 through 4. If account number 6091 (Franchise Permit Fee) is selected, request from Contract Manager documentation supporting filed cost. The selection of accounts for Testing of Expenditures will use following parameters:</p>			
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<p>1. <b>Prior Period Adjustments</b> - accounts with prior adjustments are selected for <b>substantiate tests</b> of expenditures of current period.</p> <p>2. <b>Comparison by Account Number</b> - if Current Period Per Diem exceeds Prior Period Per Diem by 2% and is \$.10 or greater, the account is selected for <b>substantiate tests</b> of expenditures. <b><i>Accounts are selected in order of highest per diem increase.</i></b> When multiple accounts have the same per diem increase, the selection of the accounts will be based upon the highest current period dollar amount ranked in descending order.</p> <p>3. Medical Supplies, account numbers 6000 and 6001, if not selected in 1 and 2, are selected in the order due to their high risk for miss reported cost, as follows:</p> <ul style="list-style-type: none"> <li>• Costs which are Direct Billed to the Department, pursuant to Rule 5101:3-3-19 of the OAC.</li> <li>• Payments for leased equipment are either Direct Billed Services or miss classified cost, which should be reported in account number 8065, Lease and Rent, Equipment, pursuant to Rule 5101:3-3-20 (M) (1) of OAC.</li> <li>• Cost which are miss classified and should be reported in account numbers 7115, Incontinence Supplies, and 7120, Personal Care. Review account descriptions of the Chart of Accounts contained in Appendix A of Rule 5101:3-3-20.1 of the OAC.</li> </ul> <p>4. <b>If Less Than Three Accounts not met criteria of Parameters 1, 2 or 3</b> select from the following listing, accounts necessary for selection of at least three (3) accounts:</p> <ol style="list-style-type: none"> <li>a. 6003 - Oxygen</li> <li>b. 6005 - Medical Minor Equipment - Billable to Medicare</li> <li>c. 6006 - Medical Minor Equipment Non-Billable to Medicare</li> <li>d. 6020 – Heat, Light &amp; Power</li> <li>e. 6040 - Trash and Refuse Removal</li> <li>f. 6050 - Hazardous Medical Waste Collection</li> <li>g. 6060 - Real Estate Taxes</li> <li>h. 6080 - Franchise Tax</li> </ol>			
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<p><b><i>The Order of Selection should be based on highest per diem increase in comparison to prior period.</i></b></p>			
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<p>5. <b>If Three (3) Accounts have not been Identified by Parameters 1, 2, 3 and 4</b> - the remaining accounts are selected using current period account balance. The Order of Selection will be accounts having highest dollar amount for current period.</p> <p><b>B. <i>Direct Care Cost</i></b> - Select at least three (3) accounts in the Direct Care Cost Center, <b>which are not examined through other Work Program Procedures</b>, using Parameters of 1 through 4. The selection of accounts for <b>substantiate tests</b> of expenditures will use the following parameters:</p> <ol style="list-style-type: none"> <li>1. <b>Risk for Miss Reported Cost</b> – Account number 6210, Consulting and Management – Direct Care; because of the strict functions/duties/services allowed in the reporting category ensure amount expense is allowable, reasonable, related to resident care and properly classified pursuant to Appendix A of Rule 5101:3-3-20.1 of OAC.</li> <li>2. <b>Prior Period Adjustments</b> - accounts with prior adjustments are selected for <b>substantiate tests</b> in current period.</li> <li>3. <b>Comparison by Account Number</b> - if the Current Period Per Diem exceeds Prior Period Per Diem by 6% and is \$.89 or greater, the account is <b>substantiate tests</b>. <b><i>Accounts are selected in order of highest per diem increase.</i></b> When multiple accounts have same per diem increase, the order of selection will be based upon the highest current period dollar amount ranked in descending order.</li> <li>4. <b>If Less Than three (3) Accounts have not met criteria of parameters 1, 2 or 3</b> – select from following listing accounts necessary for selection of at least 3 accounts:             <ol style="list-style-type: none"> <li>a. 6220 - Other Direct Care Medical Services</li> <li>b. 6300 - Registered Nurse- Purchased Nursing</li> <li>c. 6310 - Licensed Practical Nurse</li> <li>d. 6320 - Nurse Aides</li> <li>e. 6220 - Other Direct Care Medical Services</li> </ol> </li> </ol>			
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<ul style="list-style-type: none"> <li>f. 6300 - Registered Nurse- Purchased Nursing</li> <li>g. 6310 - Licensed Practical Nurse</li> <li>h. 6320 - Nurse Aides</li> </ul>			
<p><b>Continuation of 4:</b></p> <ul style="list-style-type: none"> <li>i. 6490 - Employee Fringe Benefits</li> <li>k. 6530 - Employee Fringe Benefits</li> </ul> <p><i>The Order Selection should be based on highest per diem increase in comparison to the prior period.</i></p> <p><b>5. If Three (3) Accounts have not been identified by parameters 1, 2, 3 or 4</b> - the remaining accounts are selected using current period account balance. The Order of selection will be accounts having highest dollar amount for current period.</p> <p><b>C. <u>Indirect Care Cost Center</u></b> - Select at least three (3) accounts in the Indirect Care Cost Center, <b>which are not examined through other Work Program Procedures</b>, using the Parameters of 1 through 4. The selection of accounts for <b>substantiate tests</b> will use following Parameters:</p> <ol style="list-style-type: none"> <li>1. <b>Prior Period Adjustments</b> - accounts with prior adjustments are selected for <b>substantiate tests</b> of expenditures of current period.</li> <li>2. <b>Comparison by Account Number</b> - if the Current Period Per Diem exceeds the Prior Period Per Diem by 7% and is \$.63 or greater, the account is selected for <b>substantiate tests</b> of expenditures. <b>Accounts are selected in order of highest per diem increase.</b> When multiple accounts have the same per diem increase, the selection of account will be based upon highest current period dollar amount ranked in descending order.</li> <li>3. <b>If Less Than three (3) Accounts have not met criteria of parameters 1 or 2</b> – select from following listing the accounts necessary for selection of at least 3 accounts:</li> </ol>			

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<ul style="list-style-type: none"> <li>a. 7055 - Enterals</li> <li>b. 7070 - Employee Fringe Benefits</li> </ul>			
<p><b>Continuation of 3:</b></p> <ul style="list-style-type: none"> <li>c. 7100 - Habilitation Supplies</li> <li>d. 7120 - Personal Care Supplies</li> <li>e. 7215 - Consulting &amp; MGMT</li> <li>f. 7230 - Security Services</li> <li>g. 7290 - Help Wanted/Informational Advertising</li> <li>h. 7305 - Other Indirect</li> <li>i. 7330 - Plant Operation &amp; Maintenance</li> <li>j. 7340 - Repairs and Maintenance</li> <li>k. 7350 - Minor Equipment</li> <li>l. 7520 - Employee Fringe Benefits</li> </ul> <p><i>The Order Selection should be based on highest per diem increase in comparison to the prior period.</i></p> <p><b>4. If Three (3) Accounts have not met criteria of parameters 1, 2 or 3 - the remaining accounts are selected using current period account balance. The Order of selection will be accounts having highest dollar amount for current period.</b></p>			
<p><b>II. Intermediate Care Facilities for Mentally Retarded (ICFs-MR) - Parameters Determined by Cost Center for Substantiate Testing of Expenditures</b></p>			

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<p><b>A. <i>Other Protected Costs</i></b> - Select at least three (3) accounts in the Other Protected Care Cost Center, <b>which are not examined through other Work Program Procedures</b>, using the criteria of Parameters 1 through 4. <i>Account number 6091 (Franchise Permit Fee) is omitted from the account number selected.</i> The selection of accounts for Substantiate Testing of Expenditures will use the following Parameters :</p> <p>1. <b>Prior Period Adjustments</b> - accounts with prior adjustments are selected for substantiate testing of expenditures in current period.</p> <p>2. <b>Comparison by Account Number</b> - if the Current Period Per Diem exceeds the Prior Period Per Diem by 2% and is \$.04 or greater, the account is selected for substantiate testing of expenditures. <b><i>Accounts are selected in order of highest per diem increase.</i></b> When multiple accounts have the same per diem increase, the selection of the account will be based upon the highest current period dollar amount ranked in descending order.</p> <p><b>3. If Less Than Three (3) Accounts have not met criteria of Parameters 1 and 2</b> - Medical Supplies, account numbers 6000 and 6001, if not selected in 1 and 2, are selected in the order due to their high risk for miss reported cost, as follows:</p> <ul style="list-style-type: none"> <li>• Costs which are Direct Billed to the Department, pursuant to Rule 5101:3-3-19 of the OAC.</li> <li>• Payments for leased equipment are either Direct Billed Services or miss classified cost, which should be reported in account number 8065, Lease and Rent, Equipment, pursuant to Rule 5101:3-3-20 (M) (1) of the OAC.</li> </ul>			
<p><b>Continuation of 3:</b></p> <ul style="list-style-type: none"> <li>• Cost which are miss classified and should be reported in account numbers 7115, Incontinence Supplies, and 7120, Personal Care. Review the account descriptions of the Chart of Accounts contained in Appendix A of Rule 5101:3-3-20.1 of the OAC.</li> </ul>			

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<p><b><i>The Order of Selection should be based on highest per diem increase in comparison to the prior period.</i></b></p> <p><b>If Three (3) Accounts have not been Identified by Parameters of 1, 2 or 3</b> - the remaining accounts are selected using current period account balance. The Order of selection will be accounts having the highest dollars amount for current period.</p> <p><b>B. <u>Direct Care Cost</u></b> - Select at least three (3) accounts in Direct Care Cost Center, <b>which are not examined through other Work Program Procedures</b>, using Parameters 1 through 4. The selection of accounts for Substantiate Testing of Expenditures will use the following Parameters:</p> <ol style="list-style-type: none"> <li>1. <b>Prior Period Adjustments</b> - accounts with prior adjustments are selected for sampling of expenditures in current period.</li> <li>2. <b>Comparison by Account Number</b> - if the Current Period Per Diem exceeds the Prior Period Per Diem by 3% and is \$.88 or greater, the account is selected for substantiate testing of expenditures. <b>Accounts are selected in order of highest per diem increase.</b> When multiple accounts have the same per diem increase, the selection of account will be based upon the highest current period dollar amount ranked in descending order.</li> <li>3. <b>If Less Than Two (2) Accounts have met criteria of parameters of 1 and 2</b> - select from following listing the accounts necessary for selection of at least 3 accounts:</li> </ol>			
<p><b>Continuation of Account listing from 3:</b></p> <p style="padding-left: 40px;">a. 6220 - Other Direct Care Medical Services</p>			

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<p>b. 6300 - Registered Nurse- Purchased Nursing</p> <p>c. 6310 - Licensed Practical Nurse</p> <p>d. 6320 - Nurse Aides</p> <p>e. 6530 - Employee Fringe Benefits</p> <p><b><i>The Order Selection should be based on highest per diem increase in comparison to the prior period.</i></b></p> <p><b>4. If Two (2) Accounts have not met criteria of Parameters 1, 2 and 3</b> - the remaining accounts are selected using the current period account balance. The Order of selection will be accounts having highest dollar amount for the current period.</p> <p><b>C. <u>Indirect Care Cost Center</u></b> - Select at least three (3) accounts in the Indirect Care Cost Center, which are not examined through other Work Program Procedures, using Parameters 1 through 4. The selection of accounts for Substantiate Testing of Expenditures will use the following Parameters:</p> <p><b>1. Prior Period Adjustments</b> - accounts with prior adjustments are selected for substantiate testing of expenditures in the current period.</p> <p><b>2. Comparison by Account Number</b> - if Current Period Per Diem exceeds Prior Period Per Diem by 3% and is \$.11 or greater, the account is selected for substantiate testing of expenditures.</p>			
<p><b>Continuation of 2:</b></p> <p><b>2. Comparison by Account Number</b> - if the Current Period Per Diem exceeds the Prior Period Per Diem by 3% and is \$.11 or greater, the account is selected for substantiate testing of expenditures. <b><i>Accounts are selected in order of highest per diem increase.</i></b> When multiple accounts have same per diem increase, the selection will be based upon highest current period dollar amount ranked in descending order.</p>			

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<p><b>3. If Less Than Three (3) Accounts meet criteria of Parameters 1 and 2</b> - select from following listing the accounts necessary for selection of at least 3 accounts:</p> <ul style="list-style-type: none"> <li>a. 7055 - Enterals</li> <li>b. 7070 - Employee Fringe Benefits</li> <li>c. 7100 - Habilitation Supplies</li> <li>d. 7120 - Personal Care Supplies</li> <li>e. 7215 - Consulting &amp; MGMT</li> <li>f. 7230 - Security Services</li> <li>g. 7290 - Help Wanted/Informational</li> <li>h. 7305 - Other Indirect.</li> <li>i. 7330 - Plant Operation &amp; Maintenance</li> <li>j. 7340 - Repairs and Maintenance</li> <li>k. 7350 - Minor Equipment</li> <li>l. 7520 - Employee Fringe Benefits</li> </ul> <p><b><i>The Order of Selection should be based on highest per diem increase in comparison to the prior period.</i></b></p>			
<p><b>4. If Three (3) Accounts have not met criteria of Parameters of 1, 2 or 3</b> - the remaining accounts are selected using current period account balance. The Order of Selection will be accounts having highest dollar amount for current period.</p> <p><b>III. All Long Term Care providers have the potential for revenue that must be used to offset related expenses.</b></p>			

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<p>A. Expenses attributable to following revenue accounts (and similar items) are not to be included in allowable routine costs; scan general ledger, trial balance and cost report Attachment 2 to determine that such items have been correctly eliminated. If the expense is not identifiable or cannot be segregated, then the revenue earned must be offset against the appropriate expense. <b>The revenue offset cannot exceed the reported expense.</b></p> <ol style="list-style-type: none"> <li>1. Telephone service (pay stations excluded).</li> <li>2. Radio and television service.</li> <li>3. Laundry service to other than patients.</li> <li>4. Unrestricted investment income.</li> <li>5. Employee and guest meals. Exception, if employee meal meets the Fringe Benefit Test, pursuant to CMS Pub. 15-1, Section 2144.</li> <li>6. Sale of drugs to other than patients (including going-home drugs).</li> <li>7. Sale of medical and surgical supplies to other than patients.</li> <li>8. Sale of medical records and abstracts.</li> <li>9. Sale of scrap, waste, etc.</li> <li>10. Interest Income</li> <li>11. Rebates and refunds of expenses.</li> <li>12. Vending machines.</li> </ol>			
<p><b>Continuation of A:</b></p> <ol style="list-style-type: none"> <li>13. Rental of quarters to employees and others.</li> <li>14. Payments received from specialists.</li> <li>15. Trade, quantity, time and other discounts on</li> </ol>			

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<p>purchases.</p> <p>16. Private duty nurses.</p> <p>17. Promotional Advertising.</p> <p>18. Recovery of insured loss.</p> <p>Prepare a memo summarizing the results of the completed procedures and findings. Post your adjustments to the Proposed Cost Adjustments Sheet.</p> <p>B. There are general cost and expenses that are non allowable for Medicaid reimbursement. Scan the general ledger, trial balance and Attachment 2 of cost report and ensure provider has not included in allowable the following:</p> <ol style="list-style-type: none"> <li>1. Fund-raising expenses.</li> <li>2. Bad debts.</li> <li>3. Expenses of operating gift shops, snack bars, and etc.</li> <li>4. Penalties and interest on penalties.</li> <li>5. Promotional Advertising</li> <li>6. Any other expenses not applicable to patient care.</li> </ol> <p>In general, the expenses listed would be adjusted from allowable cost as “Cost no Related to Resident Care”, pursuant to CMS Pub 15.1, Section 2102. Within Chapter 21 of CMS Pub. 15-1 certain of the expenses listed are specifically identified as Non Allowable Cost, such as promotional advertising. Familiarize with the applicable chapter to ensure the reported costs are allowable. Prepare a memo summarizing the results of the completed procedures and findings. Post your adjustments to the Proposed Cost Adjustments Sheet.</p>			
<p>C. If expenditures are reported for ancillary services such as lab, x-ray, ambulance service, physical therapy, occupational therapy, speech therapy, audiology, physicians’ salaries, etc.; ensure they have been eliminated from allowable costs. <b>Exception; for ICFs-MR, Physical Therapy, Occupational Therapy, Speech Therapy and Audiology are allowable costs.</b></p>			

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<p>A. For expenses attributed to Home Office Costs, Account Numbers:</p> <ol style="list-style-type: none"> <li>1. 6095 - Home Office Cost Other Protected Care</li> <li>2. 6230 - Home Office Cost Direct care</li> <li>3. 7310 - Home Office Cost Indirect care</li> <li>4. 8080 - Home Office Cost Capital Care</li> <li>5. 8290 - Home Office Cost Capital Care</li> </ol> <p>Obtain from the provider, if not previously provided by ODJFS, the Home Office Trial Balances of Assets, Liabilities, Revenues and Expenses. Also, obtain a copy of the provider’s support for the method of allocating cost and expenses to the various entities of the chain. Determine the following:</p> <ol style="list-style-type: none"> <li>a. <b>Assets</b> – assured assets claimed in allocated home equity meet the same requirements of Assets Work Program. Use the Asset Program Procedures to assure reported assets are allowable, reasonable and related to resident care.</li> <li>b. <b>Liabilities</b> - Assure liabilities claimed in allocated home equity meet the same requirements of Liability Work Program. Use the Asset Program Procedures to assure reported liabilities are allowable, reasonable and related to resident care.</li> <li>c. <b>Revenue Trial Balance</b> – scan the revenue trial balance for revenues, which are offset against reported cost. 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.</li> </ol>			
<p>C. If expenditures are reported for ancillary services such as lab, x-ray, ambulance service, physical therapy, occupational therapy, speech therapy, audiology, physicians’ salaries, etc.; ensure they have been eliminated from allowable costs. <b>Exception; for ICFs-MR, Physical Therapy, Occupational</b></p>			

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**AUDIT WORK PROGRAM - *LIMITED SCOPE***

Provider \_\_\_\_\_  
Name \_\_\_\_\_  
Section of Work General Section 100  
Cost Report Period \_\_\_\_\_

Provider \_\_\_\_\_  
Number \_\_\_\_\_  
Audit Date \_\_\_\_\_

<p><b>Therapy, Speech Therapy and Audiology <u>are</u> allowable costs.</b></p> <p>B. For expenses attributed to Home Office Costs, Account Numbers:</p> <ol style="list-style-type: none"> <li>1. 6095 - Home Office Cost Other Protected Care</li> <li>2. 6230 - Home Office Cost Direct care</li> <li>3. 7310 - Home Office Cost Indirect care</li> <li>4. 8080 - Home Office Cost Capital Care</li> <li>5. 8290 - Home Office Cost Capital Care</li> </ol> <p>Obtain from the provider, if not previously provided by ODJFS, the Home Office Trial Balances of Assets, Liabilities, Revenues and Expenses. Also, obtain a copy of the provider's support for the method of allocating cost and expenses to the various entities of the chain. Determine the following:</p> <ol style="list-style-type: none"> <li>a. <b>Assets</b> – assured assets claimed in allocated home equity meet the same requirements of Assets Work Program. Use the Asset Program Procedures to assure reported assets are allowable, reasonable and related to resident care.</li> <li>b. <b>Liabilities</b> - Assure liabilities claimed in allocated home equity meet the same requirements of Liability Work Program. Use the Asset Program Procedures to assure reported liabilities are allowable, reasonable and related to resident care.</li> <li>c. <b>Revenue Trial Balance</b> – scan the revenue trial balance for revenues, which are offset against reported cost. 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.</li> </ol>			
<p><b>Continuation C, Home Office Cost:</b></p> <p>d. <b>Expenditures other than Payroll</b> – review the home trial balance of</p>			

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Provider _____ Name _____ Section of Work <u>General Section 100</u> Cost Report Period _____	Provider _____ Number _____ Audit Date _____
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<p>expenses for non-allowable cost pursuant to OAC Rule 5101:3-3-01 (A). Use the criteria of III (A) of Expenditure Work Program as basis for examination.</p> <p><b>e. Home Office Allocations</b> – assure that allocation basis used is adequately supported and was rationally developed, pursuant to Section 2150 of CMS Publication 15-1. Re-test the provider’s allocation worksheets to assure that cots have been accurately allocated.</p> <p>Prepare a memo summarizing the results of the completed procedures and findings. Post your adjustments to the Proposed Cost Adjustments Sheet.</p> <p><b>IV. Review and supervision.</b></p> <p><b>V. Clear review points.</b></p>			
<p>1. Summarize the Proposed Cost Adjustment (PCAs) in the following manner:</p> <p>Prepare and maintain a Proposed Cost Adjustment (PCA) schedule. This schedule is formatted to facilitate of tracking of the inter-period effect of adjustments proposed. Adequate explanation of each adjustment should be indicated, including references to authoritative rules, work papers, account number and audit narrative number. Proposed cost adjustments should be reviewed on a timely basis with provider. <i>Note, consider the <b><u>Monetary Finding Amount</u></b> needed to make a one cent change in provider’s reimbursement rate. When Proposing Cost Adjustments (PCAs), keep in mind, the amount needed to effect the rate. Cumulate the adjustments by Cost Center. Any cumulated amount less than the amount needed to change the rate by \$.01 may be excluded from the Summary of PCAs. If omitted from the Summary of PCAs, because the amount is less than the <b><u>Monetary Finding Amount</u></b>, document the omission on the Summary of PCAs.</i></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</p>			

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Cost Report Period	Audit Date

<p>and date the proposed adjustments schedule. Note, his signature is not an omission of agreement, but documents his awareness of findings.</p> <p>3. Representative Questionnaire – have provider review and make appropriate notations to questions asked.</p> <p>4. Review Audit Working Papers - All audit findings are to be properly documented in the audit work papers. Documentation should contain the rule or law 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>			