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1 Special Attachment

See corresponding Narrative # included with report.

2 Reclassifications

Ohio Administrative Code (OAC) Rule 5101:3-3-20 states in part: "for reporting purposes NFs and ICFs-MR, other than state-operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule 5101:3-3-20.1 of the Administrative Code, or relate its chart of accounts directly to the cost report."

Reported costs were reclassified to the proper account per the reclassifications schedule attached to this report.

3. Inadequate Cost Data and Cost Finding

Ohio Administrative Code (OAC) Rule 5101:3-3-20(l) states in part: "Financial, statistical, and medical records (which shall be available to ODJFS and to the U.S. Department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed, if ODJFS issues an audit report in accordance with Rule 5101:3-3-20 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.

Furthermore, centers for Medicare and Medicaid services (CMS) Publication 15-1, Section 2304 states in part: "cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) Which pertain to the determination of reasonable cost, capable of being audited."

4 Expense Not Offset By Revenue

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2302.5 states in part... "Applicable credits -- those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs."

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5 Accrual Basis Cost Adjustment

Ohio Administrative Code (OAC) Rule 5101:3-3-20, Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) states in part... "as a condition of participation in the title xix Medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report with the Ohio Department of Job and Family Services (ODJFS). The cost report [ODJFS 2524-Appendix A of Rule 5101:3-3-20.2 of the Administrative Code] including its supplements and attachments as specified under paragraphs (a) to (o) of this Rule or other approved forms for state-operated ICFs-MR, must be filed in duplicate within ninety days after the end of the reporting period. Except as specified under paragraphs (a), (b), and (h) of this Rule, the report shall cover a calendar year or the portion of a calendar year during which the NF and ICF-MR participated in the medical assistance program. ODJFS shall issue the cost report forms; or appropriate software; or an approved list of vendors for an electronically submitted equivalent; to NFs and ICFs-MR no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule 5101:3-3-20.1 of the Administrative Code, or relate its chart of accounts directly to the cost report.

- (1) cost reports submitted by county and state-operated facilities may be completed on an accrual basis and based upon generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

6 Change in the Ratio of Allocation

As part of our examination, we have conducted a study of the allocation procedures that were used for this cost report period. Our review revealed that the allocation procedures were inadequate and we have accordingly adjusted the ratio of allocation through these audit adjustments.

7 Definition of Covered Services

OAC Section 5101:3-3-04 states... services which are covered in the per diem vendor payment include: room and board; laundry including personal laundry (not dry-cleaning); durable medical equipment and medical supplies; personal services including all routine personal hygiene of the body, hair, and nails of the hand and feet; nursing care; special dietary service; and other specialized and supportive rehabilitative services including physical therapy, occupational therapy, speech therapy, respiratory therapy, psychological services, and audio logy as prescribed by the attending physician or where appropriate, the QMRP, social services and activity programs as needed by individual residents are also included in the per diem rate. All health related services must be medically necessary and documented by physician certification and/or recertification and by the

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ongoing utilization review procedures. Specific covered services in LTCF's and the method of reimbursement are referenced in Rule 5101: 3-3-17 of the Administrative Code. (OAC 5101: 3-3-17 is effective until 12-29-93).

8 Allowable Costs not Reported

OAC 5101: 3-3-01 states in part... "allowable costs" are those costs incurred for certified beds in a facility as determined by the department of job and family services (ODJFS) to be reasonable...and (sic) are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

- (A) (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (sic);
- (2) The provider reimbursement manual ("Publication 15-1" as published by Center for Medicare and Medicaid Services)
- (3) Generally accepted accounting principles.

The provider failed to include allowable costs, which we are adding to the provider's reportable costs.

9 Chart of Accounts for Long-Term Care Facilities

OAC 5101:3-3-201 states in part..." The Ohio Department of Job and Family Services requires that all facilities file semi-annual cost reports through December 31, 1993, and annually thereafter, to comply with Section 5111.26 of the Revised Code. The use of the Chart of Accounts in Table 1 through Table 8 of this Rule is recommended to establish the minimum level of detail to allow for cost report preparation. If the recommended Chart of Accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report."

10 Prudent Buyer – Principle

CMS Publication 15-1 (aka) HIM – 15 Health Insurance Manual, Section 2103 states in part...The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

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11 Nonreimbursable Costs – Costs Not Related to Patient Care

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2102.3 states in part... "Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs"

12 Non Reimbursable Costs – Unallowable Advertising Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2136.2 states..."costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See Section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the health care financing administration and other federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients."

13 Non Reimbursable (sic) Costs – Fines and Penalties

Ohio Administrative Code (OAC) Rule5101:3-3-56 states in part: "The following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code."

A. Fine or Penalties paid under Sections 5111.28, 5111.35 to 5111.62 and 5111.99 of the Revised Code

Ohio Administrative Code (OAC) Rule5101:3-3-56 states in part: "the following costs are not reimbursable to NFs through the prospective reimbursement cost

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reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code."

- B Disallowances made during fiscal audit of the NF's cost report which are sanctioned through adjudication in accordance with Chapter 119 of the Revised Code.

An adjustment was made per audit to remove disallowances made per fiscal audit of the NF's cost report which are sanctioned through Chapter 119.

14 Nonreimbursable Costs – Disallowances

OAC 101:3-3-89 states in part...

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable (sic) costs include but are not limited to:

- (B) Disallowances made during fiscal audit of the ICF- MR's cost report which are sanctioned through adjudication in accordance with Chapter 119 of the Revised Code.

An adjustment was made per audit to remove disallowances made per fiscal audit of the ICF's-MR cost report which are sanctioned through Chapter 119.

15 Nonreimbursable (sic) Costs - Therapies

Ohio Administrative Code (OAC) Rule 5101:3-3-56 states in part: "the following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the revised Code."

- D. The costs of physical therapy, occupational therapy, audiology, and speech therapy services provided by appropriately licensed therapists or therapy assistants. This does not apply to maintenance therapy services provided by nursing staff as set forth in Rule 5101: 3-3-46 of the Administrative Code.

Adjustments were made per audit to remove direct billed items.

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16 Nonreimbursable [sic] Costs - Ancillary Services

Ohio Administrative Code (OAC) Rule 5101:3-3-56 states in part: "the following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code."

- E. The cost of ancillary services rendered to NF residents by providers who bill Medicaid directly. These services include but are not limited to: physicians, legend drugs, radiology, laboratory, oxygen, and resident-specific medical equipment.

Adjustments were made per audit to remove direct billed items.

17 Nonreimbursable [sic] Costs – Unsuccessful Lawsuits

Ohio Administrative Code (OAC) Rule 5101:3-3-56 states in part: "the following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code."

- (H) Costs associated with lawsuits filed against the Ohio Department of Job and Family Services which are not upheld by the courts. adjustments were made per audit to remove costs associated with lawsuits filed against the department but were not upheld in court.

18 Direct Billed Items - Dental Services

OAC Section 5101:3-3-19 states in part..." generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Rules 5101:3-3 of the Administrative Code are applicable."

- (A) Dental Services.

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Chapter 5101:3-5 of the Administrative Code. Personal hygiene services provided by facility staff contracted personnel are reimbursed through the facility cost report mechanism.

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19 Direct Billed Items --- Laboratory and X-ray Services

OAC Section 5101:3-3-19 states in part..." generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Rules 5101:3-3 of the Administrative Code are applicable."

(B) Laboratory and X-ray Services

Costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. All laboratory and x-ray procedures covered under the Medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Chapter 5101:3-11 of the Administrative Code.

20 Direct Billed Items - Durable Medical Equipment

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-19 of the Administrative Code, are applicable."

(C) Medical Supplier Services

Certain medical supplier services are reimbursable to the facility and others directly to the medical supply provider, as follows:

(1) Items which must be reimbursed through the facility's cost report include:

- (a) Costs incurred for "needed medical and program supplies" defined as those items which have a very limited life expectancy such as atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.
- (b) Costs incurred for "needed medical equipment" (and repair of such equipment) defined as items which can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility. Such medical equipment items include hospital beds, wheelchairs, and intermittent positive pressure breathing machines, except as noted in Paragraph (C)(2) of this Rule.

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- (c) Costs of equipment associated with oxygen administration, such as carts, regulators/humidifiers, cannulas, masks, and demurrage.

21 Direct Billed Items – Durable Medical Equipment

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-19 of the Administrative Code, are applicable."

(C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-19 of the Administrative Code, include:

- (a) Certain durable medical equipment items, specifically, ventilators, and custom made wheelchairs which have parts which are actually molded to fit the recipient.

22 Direct Billed Items - Prostheses

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

(C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

- (b) "Prostheses," defined as devices which replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as artificial arms or legs, electrolarynxes, and breast prostheses.

23 Direct Billed Items –Orthoses

OAC Section 5101:3-3-19 states in part..."Generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "Facility Cost Report Mechanism," the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code are applicable."

(C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

(C) "Orthoses," as defined as devices which assist in correcting or strengthening a

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distorted part, such as arm braces, hearing aids and batteries, abdominal binders, and corsets.

24 Direct Billed Items – Oxygen

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

(C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

(D) Contents of oxygen cylinders or tanks including liquid oxygen except that emergency stand-by oxygen is reimbursed through the facility cost report mechanism.

(E) Oxygen producing machines (concentrators) for specific use by an individual recipient.

25 Direct Billed Items - Pharmaceutical Supplies

Ohio Administrative Code (OAC) Rule 5101:3-3-19, relationship of other covered Medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services states in part...

"This Rule identifies covered services generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable.

(D) Pharmaceuticals

(1) Over-the-counter drugs not listed in the Ohio Medicaid Drug formulary, 2 drugs for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.

(2) All other pharmaceuticals which either are listed in the @Ohio Medicaid drug formulary|"or for which prior authorization was requested and approved, are reimbursable directly to the pharmacy provider for residents of NFs and ICFs-MR. Services reimbursable directly to the pharmacy provider are subject to the following conditions:

- (a) Drug amounts must be dispensed not to exceed maximum prescriptions quantities established by the Ohio Department of Job and Family Services.
- (b) Refill dates must be maintained with the original prescription record. Refills are limited to eleven times or one year, whichever comes first, or Nonscheduled drugs; five times or six months, whichever comes first, for Schedule III, IV, and V drugs; and none for Schedule II rugs.
- (c) For chronic maintenance medications, the pharmacy provider may only bill for one dispensing fee per medication per month.
- (d) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.
- (e) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF or an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy."

26 Franchise Tax Adjustment---Net Income Greater Than Minimum Tax

Regulation 2122.4 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."a franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

- C. Where a provider has net income sufficient to incur a tax greater than the minimum franchise tax, the entire tax is considered an income tax and no part of the tax is an allowable cost. For example, if the minimum tax is \$500 and the tax computed on income is \$600, then the entire \$600 is a nonallowable cost.

27 Franchise Tax Adjustment – Based Upon Several Criteria

Regulation 2122.4 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."a franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. Where the amount of the franchise tax is based upon the net income of the

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provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

- D. Where the amount of the franchise tax is based upon several criteria, one of which is net income, the amount of the franchise tax computed on net income is not an allowable cost. For example, if the minimum tax is \$500, the tax computed on net income is \$400, and the tax levy on capital stock is \$600, then \$400 remains an income tax and only the excess (\$600 - \$400) or \$200 is an allowable cost.

28 Self Insurance

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2161 states in part...

- B. Where a provider maintains a self-insurance program for other than malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, as well as unemployment compensation and workers' compensation insurance coupled with second injury coverage, or employee health-insurance coverage, provided it meets the requirements of ~2162.7, contributions to a self-insurance reserve fund referred to below are not includable in allowable costs. (see ~1218.9 for the effect on equity capital.) Although contributions to the self-insurance reserve fund are not allowable, a reserve fund established under the conditions of this Section need not be considered available for patient care in determining the necessity of borrowing under ~202.2. However, where such a program meets the following conditions, any allowable loss cannot exceed the amount of the fund as of the date of the loss; that is, the date a claim is actually paid."

(B) (1) The provider must maintain a self-insurance reserve fund to meet any actual losses that are sustained. In the event of a loss, the amount allowable will be limited to the balance in the reserve fund at the date of the loss.

(2) The provider must furnish to the intermediary pertinent details about the specific assets that are to be covered by the self-insurance reserve fund.

(3) The reserve must be maintained in a segregated account and the funds must not be commingled with any other funds.

(4) The self-insurance reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

(5) Contributions to the reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.

(6) The provider's total allowable interest expense under the Medicare

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program will be offset by income earned by invested insurance reserve funds.

- (7) Where appropriate, the provider must demonstrate the ability to effectively replace the inspection service, the loss handling service, and the legal defense service of the insurance companies.
- (8) The treatment of casualty losses sustained by the self-insurance fund shall follow the procedure provided in Section 133 FF.

29. Related Party Adjustment

Ohio Administrative Code (OAC) Rule 5101-3-3-01, Definitions states in part:

(BB) "Related Party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by the provider as detailed below:

- (1) An individual who is a relative of an owner is a related party.
- (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
- (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.
- (4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:
 - (A) A supplier is a separate bona fide organization;
 - (B) A substantial part of the supplier's business activity of the type carried on with the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;
 - (C) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;

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(D) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.

(5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "a" which owns fifty per cent of corporation "b" results in a twenty per cent indirect interest in corporation "B").

(CC) Relative of owner means an individual who is related to an owner of a NF or ICF-MR by one of the following relationships:

- (1) Spouse
- (2) Natural parent, child, or sibling
- (3) Adopted parent, child, or sibling
- (4) Step-parent, step-child, step-brother, or step-sister
- (5) Father-in-law, mother-in-law, brother-in-law, or sister-in-law
- (6) Grandparent or grandchild
- (7) Foster parent, foster child, foster brother, or foster sister

30 Related Party – Determination of a Related Organizations Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1005. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, facilities, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself. therefore, if a cost would be unallowable by the provider itself, it would be similarly unallowable to the related organization.

The principles of reimbursement of provider costs described elsewhere in this manual will generally be followed in determining the reasonableness and allowability of the related organization's costs, except where application of a principle in a non-provider entity would be clearly inappropriate (e.g., Chapter 13, inpatient routine nursing salary cost differential; Chapter 22, determination of cost of services to beneficiaries; Chapter 23, those portions pertaining to cost finding; Chapter 24, payments to providers; Chapter 25, limitations on coverage of costs; and Chapter 26, lower of costs or charges). In situations where the provider is a proprietary organization (as defined in Section 1202.4), an allowance of a reasonable return on equity capital invested and used in furnishing services, facilities and supplies to the related provider is includable as an element of the reasonable cost of the related organization. The general Rules specified in Section 1200ff for inclusion and exclusion of certain assets and liabilities in the computation of equity

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capital for providers will be similarly applied to the assets and liabilities of the related organization.

The provider must make available to the intermediary when requested, adequate documentation to support the costs incurred by the related organization, including, when required, access to the related organization's books and records, attributable to supplies and services furnished to the provider. Such documentation must include an identification of the organization's total costs, the basis of allocation of direct and indirect costs to the provider, and other entities served

31 Related Party Principle

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1000. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's-length bargaining. (Cross-refer to Section 2150ff.)

32 Related Party Organizations – Loans from or Between Owners – Principle

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1210.

A. General Rule - Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable as costs are not subtracted from assets in computing the owners' equity capital. Funds obtained through such loans are considered as invested capital of the provider. (see Chapter 2, ~218.) By not subtracting them from assets, the equity capital of the owners is increased.

The following debts representing loans from owners or related organizations are not subtracted from assets in computing equity capital

1. Loans from owners or related organizations made after June 30, 1966.
2. Loans from owners or related organizations made before July 1, 1966, where the terms and conditions of payment have been modified after June 30, 1966.
3. Non-interest-bearing loans, regardless of when the loan was made.

33 Related Party- Receivables Created by Loans from Related Organizations

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual Section 1210.

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- C. Receivables created by loans between related organizations.-receivables created by loans or other transfers of assets between related organizations are subtracted from assets in computing the owners' equity capital. As the loans or transfers of assets is the same as new or additional capital investment in the receiving organization, the removal of such receivables results in the transfer of equity capital from the lender to the borrower.

34 Interest – Necessary

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 202.2 necessary means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to patient care. For example, where funds are borrowed for purposes of investing in other than the provider's operations, interest expense is not allowable; such a loan is not considered "necessary." likewise, when borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost. Unrestricted funds derived from grants, gifts and endowments are not to be considered in the determination of excess working capital or the necessity of external borrowing.

Necessary also requires that the interest be reduced by investment income, except investment income earned by (1) grants, gifts and endowments, whether restricted or unrestricted, (2) funded depreciation (see ~226.2), (3) pension funds (see -228), and (4) deferred compensation funds (see~2140.3.c.3).

Investment income consists of the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

Any investment income (subject to offset) in excess of allowable interest expense should not be used to offset other operating expenses. See ~202.6 for special Rules regarding the treatment of investment income resulting from a pooling of funds for investment purposes.

35 Interest on Loans from Lenders Related to the Provider

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 218. One of the elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. (see Chapter 10 for the definition of control and ownership.) Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement for higher rates of interest or for unnecessary loans. This provision is intended to assure that loans are legitimate and

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needed, and that the interest rate is reasonable. Exceptions to this general Rule are contained in ~218.2 and 220.

36 Interest Paid to Partners, Stockholders, and Related Organizations

HCFA Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 218.1 generally, interest paid by the provider to partners (owners), stockholders, or related organizations of the provider is not allowable as a cost. Where the owner uses his own funds in a business, the funds are considered invested funds or capital, rather than borrowed funds. therefore, when a partner, stockholder, or related organization makes a loan to a provider, and the interest on the loan is not allowable as a cost, the loan is considered as part of the equity capital of the provider. (see Chapter 12, "return on equity capital," ~1220.4e.)

37 Personal Needs Allowance

OAC Section 5101:3-3-09 states in part...

- (A) Each Medicaid resident who receives care in an LTCF certified to participate in the Medicaid program is eligible to retain thirty dollars a month for the purchase of items and services of his or her choice. This personal needs allowance is the exclusive property of the resident to use as he or she chooses to meet personal needs. These funds cannot be used to pay for items and services provided by the LTCF which are covered by the Medicaid program.
- (K) In considering the appropriate use of the personal needs allowance, one must first determine whether the cost incurred is for items or services otherwise covered in the Medicaid program. relative to services provided by the LTCF, the cost of all items or services required to be provided by the LTCF under the conditions of participation are reimbursable only through the ODJFS payment system. The second point to consider in determining the appropriate use of personal needs allowance money is whether the purchases were made according to the resident's wishes. If a resident clearly expresses a desire for a particular brand of item not available from the LTCF, then personal needs allowance funds may be used so long as an item of reasonable quality is available to the resident at no charge. Following are some examples of appropriate and inappropriate uses for personal needs allowance monies. The examples are not all inclusive but are to be used as guidelines in determining the appropriateness of expenditure.
 - (1) Some appropriate uses of personal needs allowance funds are: church donations; cigarettes; gifts for resident's friends or relatives; hair care by barbers and cosmetologists; hair care products used for bleaching, coloring, straightening and permanent waving; life insurance premiums; liquor; newspapers; personal clothing; radio or television in resident's room; stationery and stamps; admission costs or fees associated with out-of-facility

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activities; burial plots; and dry-cleaning.

- (2) Some examples of inappropriate uses of personal needs allowance funds are: personal laundry charges; nursing supplies; surgical dressings; dietary supplies; irrigation trays; catheters, disposable under pads or diapers; drainage bags; syringes and needles; durable medical equipment; air conditioner; therapy services; podiatry services; room furnishings; soap; combs; toothbrushes, toothpowder, toothpaste, or mouthwash; shampoo; tissues; charges to resident for the use of electricity.

38 Start Up Costs - Principle

HCFA Publication 15-1-(aka) HIM-15 Health Insurance Manual, Section 2132.1

General - In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, Administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage and other interest; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from start-up costs.

Amortized start-up costs may be charged only to the "Administrative and general" cost center unless these costs can be specifically identified with a cost center or component of a provider, in which case the amortized costs must be directly assigned to the applicable cost center or component.

Unless otherwise specified herein, the provisions of this Section are effective for providers after June 30, 1976.

39 Start Up Costs – Entering Program after June 30, 1976

HCFA Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 2132.3 states in part

A. Operations begin upon entrance into the program (providers entering program after June 30, 1976).-

1. Where a provider prepares all portions of its facility for patient care services at

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the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.

2. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

40 Cost of Property and Equipment – Straight Line Depreciation

Ohio Administrative Code (OAC) Rule 5101:3-3-511, capital asset and depreciation guidelines; nursing facilities (NFs) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, NFs shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

41 Cost of Property and Equipment – Depreciation Conventions

Ohio Administrative Code (OAC) Rule 5101:3-3-51.1, capital asset and depreciation guidelines; nursing facilities (NFs) states in part:

- (E) The following depreciation conventions shall be used to calculate depreciation:
 - (1) For the six month period beginning July 1, 1993, capital assets shall be depreciated using conventions in place prior to July 1, 1993.
 - (2) For the calendar year 1994 and each calendar year thereafter, in the month that a capital asset is placed into service, no depreciation expense is recognized as an allowable expense a full month's depreciation expense is recognized in the month following the month the asset is placed into service.
- (G) Providers shall maintain the following property records:
 - (1) For assets not acquired through a change in ownership, detailed depreciation schedules listing each assets required, or...

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(H) For assets acquired through a change in ownership:

- (1) Depreciation schedules on a lump sum basis for land, building, and equipment; and...
- (2) A list of all assets disposed after-the change in ownership with the applicable dates of disposal."

42 Cost of Ownership – Acquisitions

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 108.1 states in part...

Acquisitions - If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least \$500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset, using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than \$500, or if the asset has a useful life of less than two years, its cost is allowable in the year it is acquired, subject to the provisions of -106. The provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded."

43 Cost of Ownership – Reimbursed by Government Agency

Ohio Administrative Code (OAC) Rule 5101:3-3-512, Cost of Ownership and Efficiency Incentive for Nursing Facilities (NFs) states in part...

"The desk-reviewed, actual, allowable, per diem cost of ownership established in this Rule is subject to the provisions set forth under Rule 5101:3-3-51 of the Administrative Code. The costs of ownership directly attributable to the purchase, rent, or lease of property and equipment costs from one related party to another through common ownership or control as defined under Rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase, rent, or lease of property and equipment costs or the actual costs of the related party.

- (A) The desk-reviewed, actual, allowable, per diem cost of ownership is based upon certified beds for property costs and equipment set forth under paragraphs (A)(1) to (A)(3) of this Rule for the calendar year preceding the fiscal year in which the rate will be paid, except as otherwise specified under Rules 5101:3-3-515, 5101:3-3-516, and 5101:3-3-53 of the Administrative Code. The desk-reviewed, actual, allowable, per diem cost of ownership includes:

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- (1) The costs of ownership directly related to purchasing or acquiring capital assets include:
 - (e) Depreciation expense for costs paid or reimbursed by any government agency, if that part the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period."

Adjustments were made to eliminate capital costs on items for which ODJFS has financed. These costs are considered outside the parameters of the cost report mechanism.

44 Cost of Ownership – Capitalized Items Expensed

Ohio Administrative Code (OAC) Rule5101:3-3-51.1 capital asset and depreciation guidelines; nursing facilities (NFs) states in part...

- (B) For purposes of determining if an expenditure should be capitalized, the following guidelines are utilized:
 - (1) Any expenditure for an item that costs five hundred dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life. (
 - (2) A provider may use a capitalization policy less than five hundred dollars per item, but is required to obtain prior approval from the Ohio Department of Job and Family Services (ODJFS) f the provider wishes to change its capitalization policy from its initial capitalization policy.

Adjustments were made to maintain the minimum capitalization policy exhibited by the provider.

45 Cost of Property and Equipment – Depreciation Expense on Capitalized Items

Ohio Administrative Code (OAC) Rule5101:3-3-51.1, capital asset and depreciation guidelines; nursing facilities (NFs) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, NFs shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

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Adjustments were made to recognize depreciation expense on items capitalized during the audit.

46 Cost of Property and Equipment – Classification of Costs

Per OAC 5101:3-3-20 states in part...

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:
 - (1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two (2) years or more, is to be reported in the capital cost components set forth under Rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code. the costs of equipment, including vehicles, acquired by an operating lease, executed before December 1, 1992, may be reported in the indirect care cost component, if the costs were reported as Administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992, until the current lease term expires. The costs of any new leases for equipment executed on and after December 1, 1992 and the costs of any pre-December 1, 1992 cost report shall be reported under the capital costs component. Operating lease costs for equipment, which result from extended leases under the provisions of a lease option negotiated on and after December cost component.

47 Cost of Property and Equipment – Capital Costs – Resident Transport Vehicles

Per OAC 5101:3-3-20 states in part...

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:
 - (3) The costs of resident transport vehicles are reported under the capital cost component set forth under Rules 5101:3-3-51 and 5101: 3-3-84 of the Administrative Code.

48 Cost of Property and Equipment – Existing Facilities and Lease

Per OAC 5101:3-3-515 states in part...

- (B) For a lease of a NF that was effective on may 27, 1992, the entire lease expense is an actual, allowable cost of ownership during the term of the existing lease. The entire lease expense also is an actual, allowable cost of ownership if a lease in existence on may 27, 1992, is renewed under either of the following circumstances:

- (1) The renewal is pursuant to a renewal option that was in existence on May

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27, 1992; or...

- (2) The renewal is for the same lease payment amount and between the same parties as the lease in existence on may 27, 1992.

49 Cost of Property and Equipment – Existing Facilities, Newly Leased

Per OAC 5101: 3-3-515 states in part...

- (C) For an initial lease of a NF that was in existence but not operated under a lease on May 27, 1992, actual, allowable cost of ownership includes the lesser of the following:

- (1) The annual lease expense; or
- (2) The portion of the annual lease expense that is equal to an imputed expense for depreciation and interest calculated at the inception of the lease using the lessor's historical capital asset cost basis.

50 Cost of Property and Equipment – Committed New Facility and Lease

Per OAC 5101: 3-3-515 states in part...

- (D) For a lease of a NF with a date of licensure on or after may 27, 1992, that is initially operated under a lease, actual, allowable cost of ownership shall include the annual lease expense if there was a substantial commitment of money for construction of the NF after December 22, 1992, and before July 1, 1993.

51 Cost of Property and Equipment – Uncommitted New Facility and Lease

Per OAC 5101: 3-3-515 states in part...

- (E) For a lease of a NF with a date of licensure on or after may 27, 1992, that is initially operated under a lease, and there was not a substantial commitment of money for construction of the NF after December 22, 1992, and before July 1, 1993, actual, allowable cost of ownership shall include the lesser of the following:

- (1) The annual lease expense; or
- (2) The portion of the annual lease expense that is equal to an imputed expense for depreciation and interest calculated at the inception of the lease using the lessor's historical capital asset cost basis.

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52 Nonextensive Renovations – reimbursable Expense

OAC Section 5101:3-3-513 states in part...

- (A) The desk-reviewed actual, allowable, per diem cost of nonextensive renovation includes:
- (1) The cost of purchasing or acquiring capital assets that meet the requirement of nonextensive renovation(s) set forth under this Rule includes:
 - (a) Depreciation expense for the cost of building(s) equal to the actual cost depreciated under Rule 5101:3-3-511 of the Administrative Code for nonextensive renovation. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.
 - (b) Depreciation expense for major components of property and fixed equipment equal to the actual cost depreciated under Rule 5101:3-3-51 of the Administrative Code for nonextensive renovation. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.
 - (c) Interest expense incurred on money borrowed for capital assets that qualify for nonextensive renovations.
 - (d) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period. These capital assets(s) must qualify for nonextensive renovation.
 - (e) Amortization expense of financing costs.

53 Nonextensive Renovation – General Criteria (NF) Prior to July 1, 1993

OAC Section 5101 :3-3-513 states in part...

- (B) To determine if the project qualifies as a nonextensive renovation... The project started prior to July 1, 1993, must include at least the following:
- (1) The cost of the project was more than ten thousand dollars; and

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- (2) The project does not increase the number of licensed beds; and
- (3) All of the costs of the project are incurred after July 1, 1981.

54 Nonextensive Renovation – General Criteria (NF) After June 30, 2993

OAC Section 5101 :3-3-513 states in part...

- (C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:
- (1) The project results in the betterment, improvement, or restoration of a NF beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed.
 - (2) When applying the five hundred dollars per bed requirement the following must apply:
 - (a) If the project affects only the Medicaid certified part of the facility, all Medicaid beds in the facility will be considered when applying the minimum cost criteria; or ...
 - (b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and...
 - (3) The project does not increase the number of licensed beds; and...
 - (4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in paragraph (c) of this Rule unless the project meets the definition of extensive renovation as defined under the Rule5101:3-3-01 of the Administrative Code; and ...
 - (5) The NF has obtained prior approval under Paragraph (E) of this Rule; and
 - (6) The NF has satisfied all requirements for notice to Ohio Department of Job and Family Services (ODJFS) upon completions of the project as set forth under paragraph (g)(1) of this Rule; and...
 - (7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, Rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the NF that is proposed to be renovated.

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55 Nonextensive Renovation – Definition of “Started”

OAC Section 5101 :3-3-513 states in part...

- (B) ..."started" means the physical work has begun on the project at the site of the facility. preliminary work such as planning, agency approval, feasibility surveys, and architectural drawings are not considered "started".

The provider has fallen under Section (B) or (C) with regards to their applicable qualifications

56 Renovations – Cost Overruns

Ohio Administrative Section 5101:3-3-513 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (2) The actual cost of construction of the approved cost by the greater of five percent or twenty thousand dollars." the provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

57 Renovations – Change in Plan

Ohio Administrative Section 5101:3-3-513 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (5) Any change in the scope of the nonextensive renovation project."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

58 Nonextensive Renovations – Rate of Interest

Ohio Administrative Code Section 5101:3-3-513 states in part...

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

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- (4) The actual interest rate expense exceeds the projected interest rate by two percentage points or more."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

59 Nonextensive Renovation – Amount Financed

Ohio Administrative Section 5101:3-3-513 states in part...

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

- (3) The actual amount financed exceeds the approved amount financed by greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

60 Nonextensive Renovations – Prior Approval

Ohio Administrative Section 5101:3-3-513 states in part...

- (C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:

- (5) The ICF-MR has obtained prior approval under paragraph (e) of this Rule:..."

The provider failed to notify the department of this situation, consequently an adjustment was made to reclassify the additional unapproved renovation costs to cost of ownership.

61 Disposal of Assets

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 130 states...

Depreciable assets may be disposed of through sale, scrapping, trade-in, donation, exchange, demolition, abandonment or involuntary conversions such as condemnation, fire, theft or other casualty. If disposal of a depreciable asset results in a gain. or loss, adjustment is necessary in the provider's allowable cost. The amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously included in allowable costs. The amount of loss to be included is limited to the undepreciated basis of the asset permitted under the program.

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When an asset has been retired from active service but is being held for standby or emergency services, depreciation may continue to be taken on such assets. in no case, however, can gain or loss be computed on the retired asset until the asset is actually disposed of. A gain or loss on the disposal of depreciable assets has no effect on a proprietary provider's equity capital for prior years."

62 Allocation of Costs – Direct and Indirect Allocation of Costs

Per OAC 5101:3-3-20 states in part...

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:
 - (2) Except for employers' share of payroll taxes, workers [sic] compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost center shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expensed under separate cost centers if performed by separate staff may be expensed to separate cost center based upon documented hours worked provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide of the remainder of the shift.

63 Allocation of Costs - Maintenance and Repair-Resident Transport Vehicles

Per OAC 5101:3-3-20 states in part..

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:
 - (3) The costs of resident transport vehicles...set forth under Rules 5101:3-3-51 and 5101: 3-3-84 of the Administrative Code. maintenance and repair of these vehicles is reported under the indirect care cost component.

64 Equity Capital – Goodwill

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 1214 states in part..."goodwill purchased in an acquisition prior to august 1970 of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles. However, goodwill which has not been purchased but has been internally generated as, for example,

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from a reorganization of the provider, is not includable in the provider's equity capital at any time."

65 Equity Capital – Exclusions, General Rule

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.1 assets and liabilities not related to providing patient care are not includable in the provider's equity capital. Excludable assets and liabilities not specifically treated elsewhere in this Chapter are discussed in the following Sections.

66 Equity Capital – Invested Funds

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.2 invested funds are funds diverted to income producing activities which are not related to patient care. Any portion of the provider's general funds or operating funds invested in such activities for more than 6 consecutive months is not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds" further, if the time period covered by such fund investment is interrupted by a number of withdrawals and redeposits so that the effect of such transactions is that funds are invested for more than 6 consecutive months, these invested funds are not included in equity capital.

67 Equity Capital – Assets Held in Anticipation of Expansion

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.4 land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets will also be excluded. construction-in-process and liabilities related to such construction are not includable in equity capital (see ~2154.4b2 where plans are abandoned).

68 Equity Capital – Noncompetition Agreements

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.7 in the sale of an ongoing facility, the purchaser might pay the seller a specific amount for an agreement not to compete, generally for a stated number of years. The costs of such agreements are not included in the provider's equity capital.

69 Equity Capital – Self-Insurance Reserve Fund

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.9 where a provider maintains a self-insurance program in lieu of purchasing conventional insurance, the funds in the self-insurance reserve fund must be set aside in a segregated account to cover possible losses and not used to provide patient care. Therefore, the amount

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deposited in the fund and the earnings on the self-insurance reserve remaining in the fund are not included in equity capital.

70 Home Office Capital

CMS Publication 15-1 (aka HIM-15 Health Insurance Manual Section 2152.1 computation.--where a chain provider received services from the home office and the program recognizes the costs of such services for reimbursement purposes (see ~2150.1), the provider must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care as defined in ~1202.1. In the determination of home office equity capital, assets and liabilities not related to patient care activities are excluded in the computation.

The equity capital of the home office is computed generally in the same manner as for providers (see Chapter 12). That is, a calculation is made at the end of the home offices accounting period to analyze the equity capital and changes therein during the period and to determine the amounts of home office equity capital at the end of each month in the period. However, where a negative amount is shown in the home office equity capital balance for any month, the actual negative amount of equity capital is included for that month in the provider's cost reports to determine the provider's average equity capital.

71 Home Office Costs – Determination of Allowable Costs

CMS Publication 15-1 (aka)HIM-15 Health Insurance Manual, Section 2150.2

- A. General.--home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, Administrative salaries, etc.) Are allowable to the extent they are reasonable (see ~2102.1). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. For example, certain advertising costs (see ~2136.2), some franchise taxes and other similar taxes (see ~2122.4), costs of noncompetition agreements (see ~2105.1), certain life insurance premiums (see ~2130), certain membership costs (see ~2138.3 and 2138.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner, as defined in Chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see ~902.2) and to the extent that it is reasonable (see ~902.3).

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- B. Organization, start-up, and other corporate costs.-
1. Organization costs.- The organization costs of a home office (except those preferred to below) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in ~2134ff. Section 2134.1b describes costs which are not considered allowable organization costs. In addition, reorganization costs (see ~2134.10) and stockholder servicing costs (see ~2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.
 2. Start-up costs.- Start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of ~2132ff.
 3. Costs of corporate acquisitions.- Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see ~2134.11). Additionally, costs connected with the transfer of assets o a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset(see ~104.10).
- C. Interest on loans between home office and components of chain.-where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense (see ~218 for the general Rule and218.2 and 220 for exceptions to the general Rule). Of course, interest income from other sources, as well as the interest income received by the home office where interest expense is allowed under the exceptions of 218.2 and 220, should be treated under the provisions of 222.2 or 224.2.

72 Home Office Cost allocation _ Procedure

CMS Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 2150.3

- A. Procedure.- Starting with its total costs, including those costs paid on behalf of providers (or other components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions. the remaining costs (total allowable costs) will then be allocated as stated below to all of the components - both providers and nonproviders - in the chain which received services from the home office.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation bases used must provide for the appropriate allocation of costs such as rent, Administrative salaries, organization

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costs, and other general overhead costs which are attributable to nonpatient care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general Administrative costs.

73 Home Office Cost Allocation – Costs Directly Allowable to Components

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3

- B. Costs directly allocable to components.- The initial step in the allocation process is the direct assignment of costs to the chain components. Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the chain entity for which they were incurred. For example, where such costs are paid by the home office, interest expense is allocated to the facility for which the loan was made; salaries are allocated to the facility to whose employees they apply; etc. Home offices may simplify the allocation of costs to the chain components in the cost finding process by transferring the costs which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the costs are incurred.

74 Home Office Cost Allocation – Costs Allocable on a Functional Basis

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual,
Section 2150.3

- C. Costs allocable on a functional basis.- The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain. Chain home offices may provide certain centralized services, such as central payroll or central purchasing, to the chain components. Where practical and the amounts are material, these costs must be allocated on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued; the costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Any residual allowable home office costs remaining after a functional cost allocation has been completed must be included as pooled costs and allocated as described in sub Section d. Below. The functions, or cost centers used to allocate home office costs, and the unit bases used to allocate the costs, including those for the pooled costs described in Sub Section D., must be used consistently from one home office accounting period to another.

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However, if the home office wishes to change its allocation bases and believes the change will result in more appropriate and more accurate allocations, the home office must make a written request, with its justification, to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

75 Home Office Cost Allocation – Pooled Costs in Home Office

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 2150.3

D. Pooled costs in home office.- In each home office there will be a residual amount, or "pool," of costs incurred for general management or Administrative services which cannot be allocated on a functional basis. For home office accounting periods beginning before November 1, 1976, these costs may be allocated to the components in the chain on the bases of beds, bed days, or other bases, provided the bases used equitably allocate such costs. Revenues are not generally appropriate for distributing these costs. Where the home office cannot determine its costs by functions and allocate them on a functional basis, the home office must allocate its costs as one cost center of pooled costs.

1. For home office accounting periods beginning on or after November 1, 1976, but beginning before January 1, 1983, the pooled costs of the home office must be allocated to the chain components in accordance with the following:
 - a. Where the chain consists solely of health care facilities, the pooled costs must be allocated to the components based on either inpatient days or total costs. If inpatient days are used, each facility would share in the pooled costs in the same proportion that its inpatient days bear to the total inpatient days of all the facilities in the chain. The basis of inpatient days can be used only if the entire chain consists solely of inpatient health care facilities. If the chain consists of both inpatient and noninpatient type of facility, total costs must be used as the basis of allocation. If total costs are used, each facility would share in the pooled costs in the same proportion that its total costs (excluding home office costs) bear to the total costs of all facilities in the chain. Total costs are

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costs before Medicare adjustments are made.

- B. Where the chain consists of health care facilities and organizations carrying on other types of activities, such as pharmacies, construction companies, etc., the pooled costs may be allocated to the health care facilities and nonhealth care organizations on an appropriate basis, depending upon the organization of the chain. The intermediary would be responsible for reviewing and approving the basis used. After this initial allocation, the pooled costs allocated to the health care facilities must then be allocated to each separate facility as set forth in a. Above.

76 Home Office Cost Allocation – Beginning on or after January 1, 1983

CMS Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 2150.3 states in part...

- 2. For home office accounting periods beginning on or after January 1, 1983
 - A. Pooled home office costs must be allocated on the basis of inpatient days, provided the entire chain consists solely of comparable inpatient health care facilities (e.g., the entire chain is composed solely of short term inpatient hospitals). Where this situation exists, each facility in the chain would share in the pooled costs in the same proportion that its total inpatient days bears to the total inpatient days of all the facilities in the chain.
 - B. Pooled home office costs must be allocated to chain components on the basis of total costs if the chain is composed of either unlike health care facilities (e.g., a combination of short-term hospitals, long-term hospitals, and home health agencies) or a combination of health care facilities and nonhealth care facilities (i.e., facilities engaged in activities other than the provision of health care). Under this basis, all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain. Total costs are costs before Medicare adjustments are made.

Where a chain consists of health care facilities and organizations carrying on other types of activities, pooled costs can be initially allocated to the health care facilities and nonhealth care facilities on an appropriate basis depending upon the organization of the chain, subject to intermediary approval as explained in the following paragraph. After this initial allocation has been performed, the pooled costs allocated to the health care facilities must then be distributed to these chain components in accordance with the requirements of Paragraphs A. or B. above, as appropriate.

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If evidence indicates that the use of a more sophisticated allocation basis would provide a more precise allocation of pooled home office costs to the chain components, such basis can be used in lieu of allocating on the basis of either inpatient days or total costs. However, intermediary approval must be obtained before any substitute basis can be used. The home office must make a written request with its justification to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods, unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made."

77 Home Office Cost Allocation – Inclusion in Provider Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3 states in part...

F. "Inclusion in provider costs.- Home office costs directly allocated to the chain providers should be included in each appropriate account in the provider's trial balance and then allocated through the provider's cost-finding process. The provider's share of the home office's allowable costs is included in the provider's adjusted trial balance with the provider's own allowable costs. this amount like other costs, must be allocated between patient care and nonpatient care activities." for example, the allocated share of the home office's allowable interest is included in the provider's adjusted trial balance with the provider's own allowable interest cost. Home office costs which are not directly allocated to the provider but are allocated on a functional or pooled basis should be included in the provider's cost report as part of the provider's general and Administrative cost. The allocated costs should be entered as one amount, designated under an appropriately descriptive heading such as "home office costs." any general interest expense included in these allocated costs should be reclassified in the provider's cost report to be included with the provider's interest expense before cost finding.

Although the share of the home office costs allocated to each provider may thereby become allowable costs under the program, the allowed costs of providers in a chain should not exceed the cost allowed for similar institutions not so affiliated. Thus, the costs of a chain provider (including any allowable home office costs) are not recognized or allowed to the extent they are found to be out of line with similar institutions in the same area (see ~2102ff)."

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78 Home Office Allocation – Equity Capital

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2152.3 after the home office equity capital is determined in accordance with ~2152.1 and 2152.2, the home office equity capital must be allocated to the providers and other components in the chain (including nonhealth care areas) which receive services from the home office. Any assets and liabilities on the financial records of the home office, and includable in equity capital of the home office, which are directly attributable to a particular provider or other entity in the chain, must be allocated directly to the particular provider or other entity in the chain and included in that entity's equity capital. For example, where the home office purchases equipment and transfers it to a provider, the equity in the equipment must be directly allocated to that provider. In the same manner, if the home office borrowed funds to finance the purchase of the equipment, the liability must also be allocated directly to the provider and included in the provider's equity capital computation.

Where borrowed and internally generated funds are transmitted by the home office to the providers or other entities in the chain and the funds have become so commingled as to preclude separate identification, the liability for the borrowed funds is allocated to the providers and other entities in the chain in the proportion that the funds received by that provider or other entities bear to total funds disbursed.

The equity in those assets and liabilities which are directly allocable to a particular provider must be included in the computation of the average equity capital of the provider on a monthly basis. The effect of this would be the same as if the provider itself owned the assets and owed the liabilities. Home offices can simplify the computation of home office equity capital and the allocation of equity capital to the chain components in the cost finding process by transferring the assets and liabilities which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the assets and/or liabilities become directly allocable.

The remaining home office equity capital, or "pooled" equity capital, related to patient care and computed under ~2152 must be allocated to each provider and other entity in the chain. The basis used for the allocation of pooled equity capital is the ratio that the portion of home office costs allocated to each provider or other entity bears to total home office costs. Home office costs which are directly allocable to a provider or other component in the chain (see ~2150.3b) should be excluded from the allocation base used to allocate "pooled" equity. The ratio developed for the allocation of home office equity capital must be applied to the amount of equity capital computed at the end of each month in the computation of average equity capital of the home office. In effect, the home office equity capital is considered as a group of net assets used to provide services to the providers and other entities in the chain.

The costs of these services allocated to the providers are considered to be a measure of the degree to which the related equity capital is used for the benefit of the providers. Each provider must include its allocated share of the pooled equity capital of the home office at

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the end of each month in the computation of its total equity capital for each respective month to determine its combined average equity capital upon which the return on equity capital is based.

501 Special Attachment

See corresponding narrative number included with report

502 Reclassifications

Ohio Administrative Code (OAC) Rule5101:3-3-20 states in part: "for reporting purposes NFs and ICFs-MR, other than state-operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule5101:3-3-20.1 of the Administrative Code, or relate its chart of accounts directly to the cost report."

Reported costs were reclassified to the proper account per the reclassifications schedule attached to this report.

503 Inadequate Cost Data and Cost Finding

Ohio Administrative Code (OAC) Rule5101:3-3-20(1) states in part: "financial, statistical, and medical records (which shall be available to ODJFS and to the u.s. Department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed, if ODJFS issues an audit report in accordance with Rule5101:3-3-20 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.

Furthermore, health care financing administration (HCFA) Publication 15-1, Section 2304 states in part: "cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited."

504 Expense Not Offset By Revenue

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2302.5 states in part.

NARR TEXT

"Applicable credits -- those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of overpayments or erroneous charges; and other income items which serve to reduce costs."

505 Accrual Basis Cost Adjustment

Ohio Administrative Code (OAC) Rule5101:3-3-20, Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) states in part:

"As a condition of participation in the Title XIX - Medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report with the Ohio Department of Job and Family Services (ODJFS). The cost report, [ODJFS 2524-Appendix A of Rule5101:3-3-202 of the Administrative Code] including its supplements and attachments as specified under paragraphs (a) to (o) of this Rule or other approved forms for state-operated ICFs-MR, must be filed in duplicate within ninety days after the end of the reporting period. except as specified under paragraphs (a), (b), and (h) of this Rule, the report shall cover a calendar year or the portion of a calendar year during which the NF and ICF-MR participated in the medical assistance program. ODJFS shall issue the cost report forms; or appropriate software; or an approved list of vendors for an electronically submitted equivalent; to NFs and ICFs-MR no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule5101:3-3-20.1 of the Administrative Code, or relate its chart of accounts directly to the cost report.

- (1) Cost reports submitted by county and state-operated facilities may be completed on an accrual basis and based upon generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

506 Change in the Ratio of Allocation

As part of our examination, we have conducted a study of the allocation procedures that were used for this cost report period. Our review revealed that the allocation procedures were inadequate and we have accordingly adjusted the ratio of allocation through these audit adjustments.

507 Definition of Covered Services

OAC Section 5101:3-3-04 states...

NARRTEXT

Services which are covered in the per diem vendor payment include: room and board; laundry including personal laundry (not dry-cleaning); durable medical equipment and medical supplies; personal services including all routine personal hygiene of the body, hair, and nails of the hand and feet; nursing care; special dietary service; and other specialized and supportive rehabilitative services including physical therapy, occupational therapy, speech therapy, respiratory therapy, psychological services, and audio logy as prescribed by the attending physician or where appropriate, the qMRp, social services and activity programs as needed by individual residents are also included in the per diem rate. all health related services must be medically necessary and documented by physician certification and/or recertification and by the ongoing utilization review procedures. Specific covered services in LTCF's and the method of reimbursement are referenced in Rule5101: 3-3-17 of the Administrative Code. (OAC 5101: 3-3-17 is effective until 12-29-93).

510 Prudent Buyer – Principle

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2103 states in part...

- A. General - The prudent and cost-conscious buyer not only refuses to pay more than the going price for an item or service, he/she also seeks to economize by minimizing cost. This is especially so when the buyer is an institution or organization which makes bulk purchases and can, therefore, often gain discounts because of the size of its purchases. In addition, bulk purchase of items or services often gives the buyer leverage in bargaining with suppliers for other items or services. Another way to minimize cost is to obtain free replacements or reduced charges under warranties for medical devices. Any alert and cost-conscious buyer seeks such advantages, and it is expected that Medicare providers of services will also seek them.

511 NonReimbursable Costs – Cost not Related to Patient Care

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2102.3 states in part... "costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs".

512 Nonreimbursable Costs – Unallowable Advertising Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2136.2 states..."costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

NARR TEXT

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable. See Section 2136.1 for allowability of professional contact costs and costs of advertising for the purpose of recruiting physicians as members of the provider's salaried staff. costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered as reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the intermediary of the advertising copy and its distribution may then be necessary to determine the specific objective. While it is the policy of the health care financing administration and other federal agencies to promote the growth and expansion of needed provider facilities, general advertising to promote an increase in the patient utilization of services is not properly related to the care of patients."

513 Nonreimbursable Costs – Fine and Penalties

OAC 5101:3-3-89 states in part...

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable (sic) costs include but are not limited to:

- (A) Fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62 and 5111.99 of the Revised Code.

515 Nonreimbursable Costs – Ancillary Services

5101:3-3-89 states in part...

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable (sic) costs include but are not limited to:

- (D) The cost of ancillary services rendered to ICF-MR residents by providers who bill Medicaid directly. these services include but are not limited to: physicians, legend drugs, radiology, laboratory, oxygen, and resident-specific medical equipment.

NARR TEXT

516 Nonreimbursable C costs – Unsuccessful Lawsuits

OAC 5101:3-3-89 states in part...

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable (sic) costs include but are not limited to:

- (H) Costs associated with lawsuits filed against the Ohio Department of Job and Family Services which are not upheld by the courts.

Adjustments were made per audit to remove costs associated with lawsuits filed against the department but were not upheld in court.

517 Direct Billed Items – Dental Services

OAC Section 5101:3-3-19 states in part..." generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Rules 5101:3-3 of the Administrative Code are applicable."

- (A) Dental services.

All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Chapter 5101:3-5 of the Administrative Code. Personal hygiene services provided by facility staff or contracted personnel are reimbursed through the facility cost report mechanism.

518 Direct Billed Items – Laboratory and X-Ray Services

OAC Section 5101:3-3-19 states in part..." generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Rules 5101:3-3 of the Administrative Code are applicable."

- (B) laboratory and x-ray services.

costs incurred for the purchase and administration of tuberculin tests, and for drawing specimens and forwarding specimens to a laboratory, are reimbursable through the facility's cost report. all laboratory and x-ray procedures covered under

NARR TEXT

the Medicaid program is reimbursed directly to the laboratory or x-ray provider in accordance with Chapter 5101:3-11 of the Administrative Code.

519 Direct Billed Items – Durable Medical Equipment

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

(C) Medical supplier services certain medical supplier services are reimbursable to the facility and others directly to the medical supply provider, as follows:

(1) Items which must be reimbursed through the facility's cost report include:

- (a) Costs incurred for "needed medical and program supplies" defined as those items which have a very limited life expectancy such as atomizers, nebulizers, bed pans, catheters, electric pads, hypodermic needles, syringes, incontinence pads, splints, and disposable ventilator circuits.
- (b) Costs incurred for "needed medical equipment" (and repair of such equipment) defined as items which can stand repeated use, are primarily and customarily used to serve a medical purpose, are not useful to a person in the absence of illness or injury, and are appropriate for use in the facility. such medical equipment items include hospital beds, wheelchairs, and intermittent positive pressure breathing machines, except as noted in paragraph (C)(2) of this Rule.
- (c) Costs of equipment associated with oxygen administration, such as carts, regulators/humidifiers, cannulas, masks, and demurrage.

520 Direct Billed Items – Durable Medical Equipment

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

(C)(2) services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code include:

NARR TEXT

- (A) Certain durable medical equipment items, specifically, ventilators, and custom made wheelchairs which have parts which are actually molded to fit the recipient.

521 Direct billed items - Prosthesis

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

- (C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code include:

- (B) "Prostheses," defined as devices which replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as artificial arms or legs, electrolarynxes, and breast prostheses.

522 Direct Billed Items - Orthoses

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement, as set forth in Chapter 5101:3-3 of the Administrative Code, are applicable."

- (C) (2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code, include:

- (C) "Orthoses," defined as devices which assist in correcting or strengthening a distorted part, such as arm braces, hearing aids and batteries, abdominal binders, and corsets.

523 Direct Billed Items – Oxygen

OAC Section 5101:3-3-19 states in part..."generally available to Medicaid recipients and describes the relationship of such services to those provided by the NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable."

- (C)(2) Services which are reimbursed directly to the medical supplier provider, in accordance with Chapter 5101:3-10 of the Administrative Code include:

- (D) Contents of oxygen cylinders or tanks including liquid oxygen except that emergency stand-by oxygen is reimbursed through the facility cost report

NARR TEXT

mechanism.

- (E) Oxygen producing machines (concentrators) for specific use by an individual recipient.

524 Direct Billed Items - Pharmaceuticals

Ohio Administrative Code (OAC) Rule 5101:3-3-19, relationship of other covered Medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services states in part:

"This Rule identifies covered services generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable.

(D) Pharmaceuticals

- (1) Over-the-counter drugs not listed in the "Ohio Medicaid Drug Formulary, 2 - Drugs for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.
- (2) All other pharmaceuticals which either are listed in the "Ohio Medicaid drug formulary," or for which prior authorization was requested and approved, are reimbursable directly to the pharmacy provider for residents of NFs and ICFs-MR. Services reimbursable directly to the pharmacy provider are subject to the following conditions:
 - (a) Drug amounts must be dispensed not to exceed maximum prescriptions quantities established by the Ohio Department of Job and Family Services (ODJFS).
 - (b) Refill dates must be maintained with the original prescription record. Refills are limited to eleven times or one year, whichever comes first, for nonscheduled drugs; five times or six months, whichever comes first, for Schedule III, IV, and V drugs; and none for Schedule II drugs.
 - (c) For chronic maintenance medications, the pharmacy provider may only bill for one dispensing fee per medication per month. (d) when new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.
 - (e) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs

NARR TEXT

delivered to a NF or an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy."

525 Franchise Tax Adjustment – Net Income Greater than Minimum Tax

Regulation 2122.4 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."a franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

- C. Where a provider has net income sufficient to incur a tax greater than the minimum franchise tax, the entire tax is considered an income tax and no part of the tax is an allowable cost. For example, if the minimum tax is \$500 and the tax computed on income is \$600, then the entire \$600 is a nonallowable cost.

526 Franchise Tax Adjustment – Based Upon Several Criteria

Regulation 2122.4 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part... A franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

- D. Where the amount of the franchise tax is based upon several criteria, one of which is net income, the amount of the franchise tax computed on net income is not an allowable cost. For example, if the minimum tax is \$500, the tax computed on net income is \$400, and the tax levy on capital stock is \$600, then \$400 remains an income tax and only the excess (\$600 - \$400) or \$200 is an allowable cost.

527 Self – Insurance

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2161 states in part...

- B "Where a provider maintains a self-insurance program for other than malpractice and comprehensive general liability coverage in conjunction with malpractice coverage, as well as unemployment compensation and workers' compensation insurance coupled with second injury coverage, or employee health-insurance

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coverage, provided it meets the requirements of ~2162.7, contributions to a self-insurance reserve fund referred to below are not includable in allowable costs. (see ~1218.9 for the effect on equity capital.) Although contributions to the self-insurance reserve fund are not allowable, a reserve fund established under the conditions of this Section need not be considered available for patient care in determining the necessity of borrowing under ~202.2. However, where such a program meets the following conditions, any allowable loss cannot exceed the amount of the fund as of the date of the loss; that is, the date a claim is actually paid."

- (1) The provider must maintain a self-insurance reserve fund to meet any actual losses that are sustained. In the event of a loss, the amount allowable will be limited to the balance in the reserve fund at the date of the loss.
- (2) The provider must furnish to the intermediary pertinent details about the specific assets that are to be covered by the self-insurance reserve fund.
- (3) The reserve must be maintained in a segregated account and the funds must not be commingled with any other funds.
- (4) The self-insurance reserve must be sufficient to meet losses of the type and to the extent that they would ordinarily be covered by insurance.
- (5) Contributions to the reserve must be made not less frequently than annually.
- (6) The provider's total allowable interest expense under the Medicare program will be offset by income earned by invested insurance reserve funds.
- (7) Where appropriate, the provider must demonstrate the ability to effectively replace the inspection service, the loss-handling service, and the legal defense service of the insurance companies.
- (8) The treatment of casualty losses sustained by the self-insurance fund shall follow the procedure provided in Section ~133ff.

528 Related Party Adjustment

Ohio Administrative Code (OAC) Rule 5101-3-3-01, definitions states in part:

(BB) "Related party" means an individual or organization that, to a significant extent, has common ownership with, is associated or affiliated with, has control of, or is controlled by, the provider, as detailed below:

- (1) An individual who is a relative of an owner is a related party.

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- (2) Common ownership exists when an individual or individuals possess significant ownership or equity in both provider and the other organization. Significant ownership or equity exists when an individual or individuals possess five per cent ownership or equity in both the provider and a supplier. Significant ownership or equity is presumed to exist when an individual or individuals possess ten per cent ownership or equity in both the provider and another organization from which the provider purchases or leases real property.
 - (3) Control exists when an individual or organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization.
 - (4) An individual or organization that supplies goods or services to a provider shall not be considered a related party if all the following conditions are met:
 - (A) A-supplier is a separate bona fide organization;
 - (B) A substantial part of the supplier's business activity of the type carried on with the provider and there is an open, competitive market for the types of goods or services the supplier furnishes;
 - (C) The types of goods or services are commonly obtained by other NFs or ICFs-MR from outside organizations and are not a basic element of patient care ordinarily furnished directly to patients by the facilities;
 - (D) The charge to the provider is in line with the charge for the goods or services in the open market and no more than the charge made under comparable circumstances to others by the supplier.
 - (5) The amount of indirect ownership is determined by multiplying the percentage of ownership interest at each level (e.g., forty per cent interest in corporation "a" which owns fifty per cent of corporation "b" results in a twenty per cent indirect interest in corporation "B").
- (CC) "Relative of owner~9 means in individual who is related to an owner of a NF or ICF-MR by one of the following relationships:
- (1) spouse
 - (2) natural parent, child, or sibling
 - (3) adopted parent, child, or sibling
 - (4) step-parent, step-child, step-brother, or step-sister;

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- (5) father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law
- (6) grandparent or grandchild
- (7) foster parent, foster child, foster brother or foster sister."

529 Related Party – Determination of a Related Organization’s Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1005. The related organization's costs include all reasonable costs, direct and indirect, incurred in the furnishing of services, facilities, and supplies to the provider. The intent is to treat the costs incurred by the supplier as if they were incurred by the provider itself. therefore, if a cost would be unallowable by the provider itself, it would be similarly unallowable to the related organization.

The principles of reimbursement of provider costs described elsewhere in this manual will generally be followed in determining the reasonableness and allowability of the related organization's costs, except where application of a principle in a nonprovider entity would be clearly inappropriate (e.g., Chapter 13, inpatient routine nursing salary cost differential; Chapter 22, determination of cost of services to beneficiaries; Chapter 23, those portions pertaining to cost finding; Chapter 24, payments to providers; Chapter 25, limitations on coverage of costs; and Chapter 26, lower of costs or charges). In situations where the provider is a proprietary organization (as defined in Section 1202.4), an allowance of a reasonable return on equity capital invested and used in furnishing services, facilities and supplies to the related provider is includable as an element of the reasonable cost of the related organization. The general Rules specified in Section 1200ff for inclusion and exclusion of certain assets and liabilities in the computation of equity capital for providers will be similarly applied to the assets and liabilities of the related organization.

The provider must make available to the intermediary when requested, adequate documentation to support the costs incurred by the related organization, including, when required, access to the related organization's books and records, attributable to supplies and services furnished to the provider. Such documentation must include an identification of the organization's total costs, the basis of allocation of direct and indirect costs to the provider, and other entities served.

530 Related Party Principle

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1000. Costs applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are includable in the allowable

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cost of the provider at the cost to the related organization. However, such cost must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. The purpose of this principle is two-fold: (1) to avoid the payment of a profit factor to the provider through the related organization (whether related by common ownership or control), and (2) to avoid payment of artificially inflated costs which may be generated from less than arm's length bargaining.(cross-refer to Section 2150ff.)

531 Related Party Organizations – Loans From or Between Owners – Principle

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1210

A. General Rule.- Debts representing loans from partners, stockholders, or related organizations on which interest payments are not allowable as costs are not subtracted from assets in computing the owners' equity capital. Funds obtained through such loans are considered as invested capital of the provider. (see Chapter 2, ~218.) By not subtracting them from assets, the equity capital of the owners is increased. the following debts representing loans from owners or related organizations are not subtracted from assets in computing equity capital

1. Loans from owners or related organizations made after June 30,1966.
2. Loans from owners or related organizations made before July 1,1966, where the terms and conditions of payment have been modified after June 30,1966.
3. Non-interest-bearing loans, regardless of when the loan was made.

532 Related Party – Receivables Created by Loans from Related Organizations

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual Section 1210. C. Receivables created by loans between related organizations.-receivables created by loans or other transfers of assets between related organizations are subtracted from assets in computing the owners' equity capital. As the loans or transfers of assets is the same as new or additional capital investment in the receiving organization, the removal of such receivables results in the transfer of equity capital from the lender to the borrower.

533 Interest – Necessary

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 202.2 necessary means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to patient care. Forexample, where funds are borrowed for purposes of investing in other than the provider's operations, interest expense is not allowable; such a loan is not considered "necessary." likewise, when

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borrowed funds create excess working capital, interest expense on such borrowed funds is not an allowable cost. Unrestricted funds derived from grants, gifts and endowments are not to be considered in the determination of excess working capital or the necessity of external borrowing. necessary also requires that the interest be reduced by investment income, except investment income earned by

- (1) Grants, gifts and endowments, whether restricted or unrestricted,
- (2) Funded depreciation (see ~226.2),
- (3) Pension funds (see -228), and
- (4) Deferred compensation funds (see~2140.3.c.3).

Investment income consists of the aggregate net amount realized from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable. Any investment income (subject to offset) in excess of allowable interest expense should not be used to offset other operating expenses. See ~202.6 for Special Rules regarding the treatment of investment income resulting from a pooling of funds for investment purposes.

534 Interest on Loans From Lenders Related to the Provider

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 218. One of the elements required for interest to be "proper" is that the interest be paid to a lender not related through control, ownership, or personal relationship to the borrowing organization. (see Chapter 10 for the definition of control and ownership.) Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement for higher rates of interest or for unnecessary loans. This provision is intended to assure that loans are legitimate and needed, and that the interest rate is reasonable. Exceptions to this general Rule are contained in 218.2 and 220.

535 Interest Paid to Partners, Stockholders, and Related Organizations

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 218.1 generally, interest paid by the provider to partners (owners), stockholders, or related organizations of the provider is not allowable as a cost. Where the owner uses his own funds in a business, the funds are considered invested funds or capital, rather than borrowed funds. therefore, when a partner, stockholder, or related organization makes a loan to a provider, and the interest on the loan is not allowable as a cost, the loan is considered as part of the equity capital of the provider. (see Chapter 12, "return on equity capital," ~1220.4e.)

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536 Personal Needs Allowance

OAC Sections 5101:3-3-60 for NFs and 5101:3-3-93 for ICFs-MR states in part...(a) each Medicaid resident who receives care in an LTCF certified to participate in the Medicaid program is eligible to retain thirty dollars a month for the purchase of items and services of his or her choice. This personal needs allowance is the exclusive property of the resident to use as he or she chooses to meet personal needs. These funds cannot be used to pay for items and services provided by the LTCF which are covered by the Medicaid program.

(K) In considering the appropriate use of the personal needs allowance, one must first determine whether the cost incurred is for items or services otherwise covered in the Medicaid program. Relative to services provided by the LTCF, the cost of all items or services required to be provided by the LTCF under the conditions of participation are reimbursable only through the ODJFS payment system. The second point to consider in determining the appropriate use of personal needs allowance money is whether the purchases were made according to the resident's wishes. If a resident clearly expresses a desire for a particular brand of item not available from the LTCF, then personal needs allowance funds may be used so long as an item of reasonable quality is available to the resident at no charge. Following are some examples of appropriate and inappropriate uses for personal needs allowance monies. The examples are not all inclusive but are to be used as guidelines in determining the appropriateness of an expenditure.

- (1) Some appropriate uses of personal needs allowance funds are: church nations; cigarettes; gifts for resident's friends or relatives; hair care by barbers and cosmetologists; hair care products used for bleaching, coloring, straightening, and permanent waving; life insurance premiums; liquor; newspapers; personal clothing; radio or television in resident's room; stationery and stamps; admission costs or fees associated with out-of-facility activities; burial plots; and dry-cleaning.
- (2) Some examples of inappropriate uses of personal needs allowance funds are: personal laundry charges; nursing supplies; surgical dressings; dietary supplies; irrigation trays; catheters, disposable under pads or diapers; drainage bags; syringes and needles; durable medical equipment; air conditioner; therapy services; podiatry services; room furnishings; soap; combs; toothbrushes, toothpowder, toothpaste, or mouthwash; shampoo; tissues; charges to resident for the use of electricity.

537 Start Up Costs – Principle

CMS Publication 15-1-(aka) HIM-15 Health Insurance Manual, Section 2132.1 general. - in the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as

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start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they must be capitalized as deferred charges and amortized over a number of benefiting periods.

Start-up costs include, for example, Administrative and nursing salaries; heat, gas, and electricity; taxes; insurance; mortgage and other interest; employee training costs; repairs and maintenance; housekeeping; and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs or capitalizable as construction costs must be appropriately classified as such and excluded from start-up costs.

Amortized start-up costs may be charged only to the "Administrative and general" cost center unless these costs can be specifically identified with a cost center or component of a provider, in which case the amortized costs must be directly assigned to the applicable cost center or component. unless otherwise specified herein, the provisions of this Section are effective for providers after June 30, 1976.

538 Start Up Costs – Entering Program After June 30, 2976

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 2132.3

- A. Operations begin upon entrance into the program (providers entering program after June 30, 1976).
1. Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of 60 consecutive months beginning with the month in which the first patient is admitted for treatment.
 2. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

539 Cost of Property and Equipment – Straight Line Depreciation

Ohio Administrative Code (OAC) Rule5101:3-3-84.1, capital asset and depreciation guidelines; intermediate care facilities (ICFs-MR) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, ICFs-MR shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining

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the useful life of that capital asset.

An adjustment was made per audit to recognize the provider's depreciation expense on a straight-line basis.

540 Cost of Property and Equipment – Depreciation Conventions

Ohio Administrative Code (OAC) Rule5101:3-3-84.1, Capital Asset and Depreciation Guidelines; Intermediate Care Facilities (ICFs-MR) states in part:

(E) The following depreciation conventions shall be used to calculate depreciation:

- (1) For the six month period beginning July 1, 1993, capital assets shall be depreciated sing conventions in place prior to July 1, 1993.
- (2) For the calendar year 1994 and each calendar year thereafter, in the month that a capital asset is placed into service, no depreciation expense is recognized as an allowable expense. A full month's depreciation expense is recognized in the month following the month the asset is placed into service. In the month that the capital asset is disposed, if the capital asset is not fully depreciated, the allowable depreciation expense is recognized as it is defined in Section 132 of the health care financing admin. (HCFA) Publication 15-1. At no time shall an asset be depreciated more than its adjusted basis.

541 Cost of Ownership – Acquisitions

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 108.1 states in part...

Acquisitions - If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least \$500, its cost must be capitalized, and written off ratably over the estimated useful life of the asset, using one of the approved methods of depreciation. If a depreciable asset has a historical cost of less than \$500, or if the asset has a useful life of less than two years, its cost is allowable in the year it is acquired, subject to the provisions of -106. The provider may, if it desires, establish a capitalization policy with lower minimum criteria, but under no circumstances may the above criteria be exceeded."

542 Cost of Ownership – Reimbursed by Government Agency

Ohio Administrative Code (OAC) Rule5101:3-3-84.2, Cost of Ownership and Efficiency Incentive for Intermediate Care Facility for the Mentally Retarded (ICFS-MR) states in part...

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'The desk-reviewed, actual, allowable, per diem cost of ownership established in this Rule is subject to the provisions set forth under Rule 5101:3-3-84 of the Administrative Code. The costs of ownership directly attributable to the purchase, rent, or lease of property and equipment costs from one related party to another through common ownership or control as defined under Rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase, rent, or lease of property and equipment costs or the actual costs of the related party.

(A) Desk-reviewed, actual, allowable, per diem cost of ownership is based upon certified beds for property costs and equipment set forth under paragraphs (a)(1) to (A)(3) of this Rule for the calendar year preceding the fiscal year in which the rate will be paid, except as otherwise specified under Rules 5101:3-3-845, and 5101:3-3-86 of the Administrative Code. The desk-reviewed, actual, allowable, per diem cost of ownership includes:

- (1) The costs of ownership directly related to purchasing or acquiring capital assets include:
 - (e) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period."

Adjustments were made to eliminate capital costs on items for which ODJFS has financed. These costs are considered outside the parameters of the cost report mechanism.

543 Cost of Ownership – Capitalized Items Expensed

Ohio Administrative Code (OAC) Rule 5101:3-3-84.1, Capital Asset and Depreciation Guidelines; Intermediate Care Facilities for the Mentally Retarded (ICFS-MR) states in part...

- (B) For purposes of determining if an expenditure should be capitalized, the following guidelines are utilized:
- (1) Any expenditure for an item that costs five hundred dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life.
 - (2) A provider may use a capitalization policy less than five hundred dollars per item, but is required to obtain prior approval from the Ohio Department of Job and Family Services (ODJFS) if the provider wishes to change its capitalization policy from its initial capitalization policy.

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Adjustments were made to maintain the minimum capitalization policy exhibited by the provider.

544 Cost of Property and Equipment – Depreciation Expense on Capitalized Items

Ohio Administrative Code (OAC) Rule 5101:3-3-84.1, Capital Asset and Depreciation Guidelines; Intermediate Care Facilities (ICFS-MR) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, ICFs-MR shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset. adjustments were made to recognize depreciation expense on items capitalized during the audit.

545 Cost of Property and Equipment – Classification of Costs

Per OAC 5101:3-3-20 states in part...

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:
 - (1) All depreciable equipment valued at five hundred dollars or more per item and a useful life of at least two (2) years or more, is to be reported in the capital cost components set forth under Rules 5101:3-3-51 and 5101:3-3-84 of the Administrative Code. the costs of equipment, including vehicles, acquired by an operating lease, executed before December 1, 1992, may be reported in the indirect care cost component, if the costs were reported as Administrative and general costs on the facility's cost report for the cost reporting period ending December 31, 1992, until the current lease term expires. The costs of any new leases for equipment executed on and after December 1, 1992 and the costs of any pre-December 1, 1992 cost report shall be reported under the capital costs component. Operating lease costs for equipment, which result? from extended leases under the provisions of a lease option negotiated on and after December 1,1992, shall be reported under the capital cost component.

546 Cost of Property and Equipment – Capital Costs – Resident Transport Vehicles

Per OAC 5101:3-3-20 states in part...

- (O) When completing cost reports, the following guidelines shall be used to properly classify costs:

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- (3) The costs of resident transport vehicles are reported under the capital cost component set forth under Rules 5101:3-3-51 and 5101: 3-3-84 of the Administrative Code.

547 Nonextensive Renovations – Reimbursable Expense

OAC Section 5101:3-3-84.2 states in part...

(A) "The desk-reviewed actual, allowable, per diem cost of nonextensive renovation includes:

- (1) The cost of purchasing or acquiring capital assets that meet the requirement of nonextensive renovation(s) set forth under this Rule includes:
 - (a) Depreciation expense for the cost of building(s) equal too the actual cost depreciated under Rule5101:3-3-841 of the Administrative Code for nonextensive renovation. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.
 - (b) Depreciation expense for major components of property and fixed equipment equal to the actual cost depreciated under Rule5101 :3-3-841 of the Administrative Code for nonextensive renovation. The provider is not to change the accumulated depreciation that has been previously reported. This accumulated depreciation will be carried forward as previously reported and audited. The current depreciation will then be added to accumulated depreciation as recognized.
 - (c) Interest expense incurred on money borrowed for capital assets that qualify for nonextensive renovations.
 - (d) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period. These capital assets(s) qualify for nonextensive renovation.
 - (e) Amortization expense of financing costs.

548 Nonextensive Renovation – General Criteria (NF) Prior to July 1, 1993

OAC Section 5101 :3-3-84.3 states in part...

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(B) ...to determine if the project qualifies as a nonextensive renovation... The project started prior to July 1, 1993, must include at least the following:

- (1) The cost of the project was more than ten thousand dollars; and
- (2) The project does not increase the number of licensed beds; and
- (3) All of the costs of the project are incurred after July 1, 1981.

549 Nonextensive Renovation – General Criteria (NF) after June 30, 1993

OAC Section 5101 :3-3-84.3 states in part...

(C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:

- (1) The project results in the betterment, improvement, or restoration of an ICF beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed.
- (2) When applying the five hundred dollars per bed requirement the following must apply:
 - (a) If the project affects only the Medicaid certified part of the facility, all Medicaid beds in the facility will be considered when applying the minimum cost criteria; or
 - (b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and
- (3) The project does not increase the number of licensed beds; and
- (4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in Paragraph (C) of this Rule unless the project meets the definition of extensive renovation as defined under the Rule5101:3-3-01 of the Administrative Code; and
- (5) The ICF-MR has obtained prior approval under Paragraph (E) of this Rule; and
- (6) The ICF-MR has satisfied all requirements for notice to Ohio department of job and family services (ODJFS) upon completions of the project as set forth under Paragraph (G)(1) of this Rule; and

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- (7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, Rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the ICF-MR that is proposed to be renovated.

550 Nonextensive Renovation – Definition of “Started”

OAC Section 5101 :3-3-84.3 states in part...

- (B) ..."started" means the physical work has begun on the project at the site of the facility. preliminary work such as planning, agency approval, feasibility surveys, and architectural drawings are not considered "started".

The provider has fallen under Section (B) or (C) with regards to their applicable qualifications

551 Renovations - Cost Overruns

Ohio Administrative Section 5101:3-3-84.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (2) The actual cost of construction of the approved cost by the greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

552 Renovations - Change in Plan

Ohio Administrative Section 5101:3-3-84.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (5) Any change in the scope of the nonextensive renovation project.

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

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553 Nonextensive Renovations - Rate of Interest

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Ohio Administrative Code Section 5101:3-3-84.3 states in part...

(F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

- (4) The actual interest rate expense exceeds the projected interest rate by two percentage points or more."

The provider failed to notify the department of this situation, consequently an adjustment was made to reclassify the additional unapproved renovation costs to cost of ownership.

554 Nonextensive Renovation - Amount Financed

Ohio Administrative Section 5101:3-3-84.3 states in part:

(F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

- (3) The actual amount financed exceeds the approved amount financed by greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

555 Nonextensive Renovations - Prior Approval

Ohio Administrative Section 5101:3-3-84.3 states in part...

(C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:

- (5) The ICF-MR has obtained prior approval under paragraph (e) of this Rule:..."

The provider failed to notify the department of this situation, consequently an adjustment was made to reclassify the additional unapproved renovation costs to cost of ownership.

556 Disposal of Assets

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CMS Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 130 states...
"Depreciable assets may be disposed of through sale, scrapping, trade-in, donation, exchange, demolition, abandonment or involuntary conversions such as condemnation, fire, theft or other casualty. If disposal of a depreciable asset results in a gain, or loss, adjustment is necessary in the provider's allowable cost. The amount of gain included in the determination of allowable cost is limited to the amount of depreciation previously included in allowable costs. The amount of loss to be included is limited to the undepreciated basis of the asset permitted under the program. When an asset has been retired from active service but is being held for standby or emergency services, depreciation may continue to be taken on such assets. In no case, however, can gain or loss be computed on the retired asset until the asset is actually disposed of. A gain or loss on the disposal of depreciable assets has no effect on a proprietary provider's equity capital for prior years."

557 Allocation of Costs – Direct and Indirect Allocation of Costs

Per OAC 5101:3-3-20 states in part...

(O) When completing cost reports, the following guidelines shall be used to properly classify costs:

- (2) Except for employers' share of payroll taxes, workers [sic] compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost center shall not be allowed. Wages and benefits for staff including related parties who perform duties directly related to functions performed in more than one cost center which would be expensed under separate cost centers if performed by separate staff may be expensed to separate cost center based upon documented hours worked provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide of the remainder of the shift.

558 Allocation of Costs – Maintenance and Repair – Resident Transport Vehicles

Per OAC 5101:3-3-20 states in part...

(O) When completing cost reports, the following guidelines shall be used to properly classify costs:

- (3) The costs of resident transport vehicles...set forth under Rules 5101:3-3-51 and 5101: 3-3-84 of the Administrative Code. Maintenance and repair of these vehicles is reported under the indirect care cost component.

559 Equity Capital – Goodwill

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HCFA Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 1214 states in part..."goodwill purchased in an acquisition prior to august 1970 of an existing organization is includable in the provider's equity capital. The amount of goodwill is determined in accordance with generally accepted accounting principles. However, goodwill which has not been purchased but has been internally generated as, for example, from a reorganization of the provider, is not includable in the provider's equity capital at any time."

560 Equity Capital – Exclusions, General Rule

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.1 assets and liabilities not related to providing patient care are not includable in the provider's equity capital. Excludable assets and liabilities not specifically treated elsewhere in this Chapter are discussed in the following Sections.

561 Equity Capital – invested Funds

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.2 invested funds are funds diverted to income producing activities which are not related to patient care. any portion of the provider's general funds or operating funds invested in such activities for more than 6 consecutive months is not includable in the provider's equity capital. For example, funds deposited in a savings account or invested in securities or loans are considered "invested funds". Further, if the time period covered by such fund investment is interrupted by a number of withdrawals and redeposits so that the effect of such transactions is that funds are invested for more than 6 consecutive months, these invested funds are not included in equity capital.

562 Equity Capital – Assets Held in Anticipation of Expansion

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.4 land, buildings, or other assets acquired in anticipation of expansion are not includable in equity capital as long as they are not being used in the operation or maintenance of patient care activities. Liabilities related to these assets will also be excluded. construction-in-process and liabilities related to such construction are not includable in equity capital (see ~2154.4b2 where plans are abandoned).

563 Equity Capital – Noncompetition Agreements

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.7 in the sale of an ongoing facility, the purchaser might pay the seller a specific amount for an agreement not to compete, generally for a stated number of years. The costs of such agreements are not included in the provider's equity capital.

564 Equity Capital – Self-Insurance Reserve Fund

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HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.9 where a provider maintains a self-insurance program in lieu of purchasing conventional insurance, the funds in the self-insurance reserve fund must be set aside in a segregated account to cover possible losses and not used to provide patient care. Therefore, the amount deposited in the fund and the earnings on the self-insurance reserve remaining in the fund are not included in equity capital.

565 Home Office Equity Capital

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual Section 2152.1 computation.-- where a chain provider received services from the home office and the program recognizes the costs of such services for reimbursement purposes (see ~2150.1), the provider must include in its equity capital computation its proportionate share of the equity capital of the home office which is related to patient care as defined in ~1202.1. In the determination of home office equity capital, assets and liabilities not related to patient care activities are excluded in the computation. the equity capital of the home office is computed generally in the same manner as for providers (see Chapter 12). That is, a calculation is made at the end of the home office's accounting period to analyze the equity capital and changes therein during the period and to determine the amounts of home office equity capital at the end of each month in the period. However, where a negative amount is shown in the home office equity capital balance for any month, the actual negative amount of equity capital is included for that month in the provider's cost reports to determine the provider's average equity capital.

566 Home office Costs – Determination of Allowable Costs

HCFA Publication 15-1 (aka)HIM-15 Health Insurance Manual, Section 2150.2

A. General.--home office costs directly related to those services performed for individual providers which relate to patient care, plus an appropriate share of indirect costs (overhead, rent, Administrative salaries, etc.) Are allowable to the extent they are reasonable (see ~2102.1). Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. for example, certain advertising costs (see 2136.2), some franchise taxes and other similar taxes (see ~2122.4), costs of noncompetition agreements (see ~2105.1), certain life insurance premiums (see 2130), certain membership costs (see 2138.3 and 2138.4) or those costs related to nonmedical enterprises are not considered allowable home office costs. In addition, where an owner, as defined in Chapter 9, received compensation for services provided by the home office, the compensation is allowable only to the extent that it is related to patient care (see ~902.2) and to the extent that it is reasonable (see ~902.3).

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- B. Organization, start-up, and other corporate costs.-
1. Organization costs.--The organization costs of a home office (except those referred to below) are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions in ~2134ff. Section 2134.1b describes costs which are not considered allowable organization costs. In addition, reorganization costs (see ~2134.10) and stockholder servicing costs (see ~2134.9) are not allowable organization costs. These unallowable organization costs are excluded from the computation of the home office equity capital.
 2. Start-up costs.-- start-up costs of a home office are considered allowable costs under the Medicare program and must be amortized in accordance with the provisions of ~2132ff.
 3. Costs of corporate acquisitions.-- Costs related to the acquisition of the capital stock of a provider, whether or not such facilities are participating or subsequently will participate in the Medicare program, are not allowable (see ~2134.11). Additionally, costs connected with the transfer of assets to a chain are not allowable as organization costs but instead must be capitalized as part of the cost of the asset(see ~104.10).
- C. Interest on loans between home office and components of chain.-where the home office makes a loan to, or borrows money from, one of the components of the chain, the interest paid is generally not an allowable cost and the interest income earned from such a loan is not used to reduce allowable interest expense (see ~218 for the general Rule and ~218.2 and 220 for exceptions to the general Rule).

567 Home Office Cost Allocation – Procedure

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual,
Section 2150.3

- A. Procedure.-Starting with its total costs, including those costs paid on behalf of providers (or other components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions. The remaining costs (total allowable costs) will then be allocated as stated below to all of the components - both providers and nonproviders - in the chain which received services from the home office.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation bases used must provide for the appropriate allocation of costs such as rent, Administrative salaries, organization costs, and other general overhead costs which are attributable to nonpatient

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care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general Administrative costs.

568 Home Office Cost Allocation – Costs Directly Allocable to Components

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3

- B. Costs directly allocable to components.-- The initial step in the allocation process is the direct assignment of costs to the chain components. Allowable costs incurred for the benefit of, or directly attributable to, a specific provider or nonprovider activity must be allocated directly to the chain entity for which they were incurred. for example, where such costs are paid by the home office, interest expense is allocated to the facility for which the loan was made; salaries are allocated to the facility to whose employees they apply; etc. Home offices may simplify the allocation of costs to the chain components in the cost finding process by transferring the costs which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the costs are incurred.

569 Home Office Cost Allocation – Costs allocable on a Functional Basis

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3

- C. Costs allocable on a functional basis.-- The allowable home office costs that have not been directly assigned to specific chain components must be allocated among the providers (and any nonprovider activities in which the home office may be engaged) on a basis designed to equitably allocate the costs over the chain components or activities receiving the benefits of the costs. This allocation must be made in a manner reasonably related to the services received by the entities in the chain. Chain home offices may provide certain centralized services, such as central payroll or central purchasing, to the chain components. Where practical and the amounts are material, these costs must be allocated on a functional basis. For example, costs of a central payroll operation could be allocated to the chain components based on the number of checks issued; the costs of a central purchasing function could be allocated based on purchases made or requisitions handled. Any residual allowable home office costs remaining after a functional cost allocation has been completed must be included as pooled costs and allocated as described in Sub Section D below. The functions, or cost centers used to allocate home office costs, and the unit bases used to allocate the costs, including those for the pooled costs described in Sub Section D must be used consistently from one home office accounting period to another.

However, if the home office wishes to change its allocation bases and believes the

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change will result in more appropriate and more accurate allocations, the home office must make a written request, with its justification, to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made. \

570 Home Office Cost Allocation – Pooled Costs in Home Office

HCFA Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 2150.3

- D. Pooled costs in home office.-- In each home office there will be a residual amount, or "pool," of costs incurred for general management or Administrative services which cannot be allocated on a functional basis. For home office accounting periods beginning before November 1, 1976, these costs may be allocated to the components in the chain on the bases of beds, bed days, or other bases, provided the bases used equitably allocate such costs. Revenues are not generally appropriate for distributing these costs. Where the home office cannot determine its costs by functions and allocate them on a functional basis, the home office must allocate its costs as one cost center of pooled costs.
1. For home office accounting periods beginning on or after November 1, 1976, but beginning before January 1, 1983, the pooled costs of the home office must be allocated to the chain components in accordance with the following:
 - a. Where the chain consists solely of health care facilities, the pooled costs must be allocated to the components based on either inpatient days or total costs. If inpatient days are used, each facility would share in the pooled costs in the same proportion that its inpatient days bear to the total inpatient days of all the facilities in the chain. The basis of inpatient days can be used only if the entire chain consists solely of inpatient health care facilities. If the chain consists of both inpatient and noninpatient type of facility, total costs must be used as the basis of allocation. If total costs are used, each facility would share in the pooled costs in the same proportion that its total costs (excluding home office costs) bear to the total costs of all facilities in the chain. Total costs are costs before Medicare adjustments are made.

NARR TEXT

- b. Where the chain consists of health care facilities and organizations carrying on other types of activities, such as pharmacies, construction companies, etc., the pooled costs may be allocated to the health care facilities and nonhealth care organizations on an appropriate basis, depending upon the organization of the chain. The intermediary would be responsible for reviewing and approving the basis used. After this initial allocation, the pooled costs allocated to the health care facilities must then be allocated to each separate facility as set forth in a. Above.

571 Home Office Cost Allocation – Beginning on or After January 1, 1983

HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3 (d) states in part...

2. "For home office accounting periods beginning on or after January 1, 1983:
 - a. Pooled home office costs must be allocated on the basis of inpatient days, provided the entire chain consists solely of comparable inpatient health care facilities (e.g., the entire chain is composed solely of short term inpatient hospitals). Where this situation exists, each facility in the chain would share in the pooled costs in the same proportion that its total inpatient days bears to the total inpatient days of all the facilities in the chain.
 - b. Pooled home office costs must be allocated to chain components on the basis of total costs if the chain is composed of either unlike health care facilities (e.g., a combination of short-term hospitals, long-term hospitals, and home health agencies) or a combination of health care facilities and nonhealth care facilities (i.e., facilities engaged in activities other than the provision of health care). Under this basis, all chain components will share in the pooled home office costs in the same proportion that the total costs of each component (excluding home office costs) bear to the total costs of all components in the chain. Total costs are costs before Medicare adjustments are made.

Where a chain consists of health care facilities and organizations carrying on other types of activities, pooled costs can be initially allocated to the health care facilities and nonhealth care facilities on an appropriate basis depending upon the organization of the chain, subject to intermediary approval as explained in the following paragraph. After this initial allocation has been performed, the pooled costs allocated to the health care facilities must then be distributed to these chain components in accordance with the requirements of Paragraphs A. Or B. above, as appropriate.

NARR TEXT

If evidence indicates that the use of a more sophisticated allocation basis would provide a more precise allocation of pooled home office costs to the chain components, such basis can be used in lieu of allocating on the basis of either inpatient days or total costs. However, intermediary approval must be obtained before any substitute basis can be used. The home office must make a written request with its justification to the intermediary responsible for auditing the home office cost for approval of the change no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The intermediary's approval of a home office request will be furnished to the home office in writing. Where the intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods, unless the intermediary approves a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made."

572 Home Office Cost Allocation – Inclusion in Provider Costs

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2150.3 states in part... F. "inclusion in provider costs.-- home office costs directly allocated to the chain providers should be included in each appropriate account in the provider's trial balance and then allocated through the provider's cost-finding process. The provider's share of the home office's allowable costs is included in the provider's adjusted trial balance with the provider's own allowable costs. This amount like other costs, must be allocated between patient care and nonpatient care activities." for example, the allocated share of the home office's allowable interest is included in the provider's adjusted trial balance with the provider's own allowable interest cost. home office costs which are not directly allocated to the provider but are allocated on a functional or pooled basis should be included in the provider's cost report as part of the provider's general and Administrative cost. The allocated costs should be entered as one amount, designated under an appropriately descriptive heading such as "home office costs." any general interest expense included in these allocated costs should be reclassified in the provider's cost report to be included with the provider's interest expense before cost finding.

"Although the share of the home office costs allocated to each provider may thereby become allowable costs under the program, the allowed costs of providers in a chain should not exceed the cost allowed for similar institutions not so affiliated. Thus, the costs of a chain provider (including any allowable home office costs) are not recognized or allowed to the extent they are found to be out of line with similar institutions in the same area (see ~2102ff)."

573 Home Office Cost Allocation – Equity Capital

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CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2152.3 after the home office equity capital is determined in accordance with ~2152.1 and 2152.2, the home office equity capital must be allocated to the providers and other components in the chain (including nonhealth care areas) which receive services from the home office. Any assets and liabilities on the financial records of the home office, and includable in equity capital of the home office, which are directly attributable to a particular provider or other entity in the chain, must be allocated directly to the particular provider or other entity in the chain and included in that entity's equity capital. For example, where the home office purchases equipment and transfers it to a provider, the equity in the equipment must be directly allocated to that provider. In the same manner, if the home office borrowed funds to finance the purchase of the equipment, the liability must also be allocated directly to the provider and included in the provider's equity capital computation.

Where borrowed and internally generated funds are transmitted by the home office to the providers or other entities in the chain and the funds have become so commingled as to preclude separate identification, the liability for the borrowed funds is allocated to the providers and other entities in the chain in the proportion that the funds received by that provider or other entities bear to total funds disbursed. The equity in those assets and liabilities which are directly allocable to a particular provider must be included in the computation of the average equity capital of the provider on a monthly basis. The effect of this would be the same as if the provider itself owned the assets and owed the liabilities. Home offices can simplify the computation of home office equity capital and the allocation of equity capital to the chain components in the cost finding process by transferring the assets and liabilities which are directly allocable to the components through the intercompany accounts. The transfers should be made at the time the assets and/or liabilities become directly allocable.

The remaining home office equity capital, or "pooled" equity capital, related to patient care and computed under ~2152 must be allocated to each provider and other entity in the chain. The basis used for the allocation of pooled equity capital is the ratio that the portion of home office costs allocated to each provider or other entity bears to total home office costs. Home office costs which are directly allocable to a provider or other component in the chain (see ~2150.3b) should be excluded from the allocation base used to allocate "pooled" equity. The ratio developed for the allocation of home office equity capital must be applied to the amount of equity capital computed at the end of each month in the computation of average equity capital of the home office. In effect, the home office equity capital is considered as a group of net assets used to provide services to the providers and other entities in the chain. The costs of these services allocated to the providers are considered to be a measure of the degree to which the related equity capital is used for the benefit of the providers. Each provider must include its allocated share of the pooled equity capital of the home office at the end of each month in the computation of its total equity capital for each respective month to determine its combined average equity capital upon which the return on equity capital is based.

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600 Inadequate Cost Data and Cost Finding

Ohio Administrative Code (OAC) Rule5101:3-3-20 (l) states in part: "financial, statistical, and medical records (which shall be available to ODJFS and to the u.s. Department of Health and Human Services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed, if ODJFS issues an audit report in accordance with Rule5101:3-3-21 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.

Furthermore, center for Medicare and Medicaid services (CMS) Publication 15-1, Section 2304 states in part: "cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost, capable of being audited.

601 Accrual Basis Cost Adjustment

Ohio Administrative Code (OAC) Rule5101:3-3-20, Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) states in part..."as a condition of participation in the title xix Medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report with the Ohio Department of Job and Family Services (ODJFS). The cost report (ODHS 2524) Appendix A of Rule5101:3-3-202 of the Administrative Code] including its supplements and attachments as specified under paragraphs (a) to (o) of this Rule or other approved forms for state-operated ICFs-MR, must be filed in duplicate within ninety days after the end of the reporting period. Except as specified under Paragraphs (A),(B), and (H) of this Rule, the report shall cover a calendar year or the portion of a calendar year during which the NF and ICF-MR participated in the medical assistance program. ODJFS shall issue the cost report forms; or appropriate software; or an approved list of vendors for an electronically submitted equivalent; to NFs and ICFs-MR no later than sixty days prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule5101:3-3-201 of the Administrative Code, or relate its chart of accounts directly to the cost report.

- I. Cost reports submitted by county and state-operated facilities may be completed on an accrual basis and based upon generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

602 Allowable Costs not Reported

NARR TEXT

OAC 5101:: 3-3-01 states in part... "allowable costs" are those costs incurred for certified beds in a facility as determined by the department of job and human services (ODJFS) to be reasonable...and (sic) are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

(A) (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (sic):
(A) (2) The Provider Reimbursement Manual ("Centers for Medicare and Medicaid Services" a.k.a. HCFA 15-1); or...

(A) (3) General Accepted Accounting Principles

The provider failed to include allowable costs, which e are adding to the provider's reportable costs.

603 Chart of Accounts for Long-Term Care Facilities

OAC 5101:3-3-20.1 states in part..." the Ohio Department of Job and Family Services requires that all facilities file semi-annual cost reports through December 31, 1993, and annually thereafter, to comply with Section 5111.26 of the revised Code. The use of the chart of accounts in table 1 through table 8 of this Rule is recommended to establish the minimum level of detail to allow for cost report preparation. If the recommended chart of accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report."

604 Nonreimbursable (sic) Costs – Unsuccessful Lawsuits

Ohio Administrative Code (OAC) Rule5101:3-3-56 states in part: "the following costs are not reimbursable to NFs through the prospective reimbursement cost reporting mechanism. Except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable [sic] cost fines or penalties paid under Sections 5111.28, 5111.35 to 5111.62, and 5111.99 of the Revised Code."

(H) Costs associated with lawsuits filed against the Ohio Department of Job and Family Services which are not upheld by the courts. adjustments were made per audit to remove costs associated with lawsuits filed against the department but were not upheld in court.

605 Direct Billed Items – Pharmaceutical Supplies

Ohio Administrative Code (OAC) Rule5101:3-3-19, relationship of other covered Medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services states in part...

NARRTEXT

"This Rule identifies covered services generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable.

(D) Pharmaceuticals

- (1) Over-the-counter drugs not listed in the "Ohio Medicaid Drug Formulary, 2 - Drugs for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.
- (2) All other pharmaceuticals which either are listed in the ~@ Ohio Medicaid Drug Formulary." or for which prior authorization was requested and approved, are reimbursable directly to the pharmacy provider for residents of NFs and ICFs-MR. Services reimbursable directly to the pharmacy provider are subject to the following conditions:
 - (a) Drug amounts must be dispensed not to exceed maximum prescriptions quantities established by the Ohio Department of Job and Family Services (ODJFS).
 - (b) Refill dates must be maintained with the original prescription record. Refills are limited to eleven times or one year, whichever comes first, for nonscheduled drugs; five times or six months, whichever comes first, for Schedule III, IV and V drugs; and none for Schedule II drugs.
 - (c) For chronic maintenance medications, the pharmacy provider may only bill for one dispensing fee per medication per month.
 - (d) When new prescriptions are necessary following expiration of the last refill, the new prescription may be ordered only after the physician examines the patient.
 - (e) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF or an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy."

606 Cost of Ownership – Capitalized Items Expensed

NARR TEXT

Ohio Administrative Code (OAC) Rule 5101:3-3-51.1, capital asset and depreciation guidelines; nursing facilities (NFs) states in part...

- (B) For purposes of determining if an expenditure should be capitalized, the following guidelines are utilized:
- (1) Any expenditure for an item that costs five hundred dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life.
 - (2) A provider may use a capitalization policy less than five hundred dollars per item, but is required to obtain prior approval from the Ohio Department of Job and Family Services (ODJFS) if the provider wishes to change its capitalization policy from its initial capitalization policy. adjustments were made to maintain the minimum capitalization policy exhibited by the provider.

607 Nonextensive Renovation – General Criteria (NF) After June 30, 1993

OAC Section 5101 :3-3-51.3 states in part...

- (C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:
- (1) The project results in the betterment, improvement, or restoration of a NF beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed.
 - (2) When applying the five hundred dollars per bed requirement the following must apply:
 - (a) If the project affects only the Medicaid certified part of the facility, all Medicaid beds in the facility will be considered when applying the minimum cost criteria; or ...
 - (b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and...
 - (3) The project does not increase the number of licensed beds; and...
 - (4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in Paragraph (C) of this Rule unless the project meets the definition of extensive renovation as defined under the Rule 5101:3-3-01 of the Administrative Code; and ...

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- (5) The NF has obtained prior approval under paragraph (e) of this Rule; and
- (6) The NF has satisfied all requirements for notice to Ohio Department of Job and Family Services (ODJFS) upon completions of the project as set forth under Paragraph (G)(1) of this Rule; and...
- (7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, Rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the NF that is proposed to be renovated.

608 Inadequate Cost Data and Cost Finding

Ohio Administrative Code (OAC) Rule5101:3-3-20(l) states in part: "financial, statistical, and medical records (which shall be available to ODJFS and to the u.s. Department of health and human services and other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed, if ODJFS issues an audit report in accordance with Rule5101:3-3-21 of the Administrative Code, or six years after all appeal rights relating to the audit report are exhausted.

Furthermore, health care financing administration (HCFA) Publication 15-1, Section 2304 states in part: "cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries. This includes all ledgers, books, records, and original evidences of cost (purchase requisitions, purchase orders, vouchers, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) Which pertain to the determination of reasonable cost, capable of being audited?"

609 Accrual Basis Cost Adjustment

Ohio Administrative Code (OAC) Rule5101:3-3-20, Medicaid cost report filing, record retention, and disclosure requirements for nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) states in part: "as a condition of participation in the Title XIX Medicaid program, each nursing facility (NF) and intermediate care facility for the mentally retarded (ICF-MR) shall file a cost report with the Ohio Department of Job and Family Services (ODJFS). The cost report, [ODJFS 2524-Appendix A of Rule5101:3-3-202 of the Administrative Code] including its supplements and attachments as specified under paragraphs (a) to (o) of this Rule or other approved forms for state-operated ICFs-MR, must be filed in duplicate within ninety days after the end of the reporting period. except as specified under paragraphs (a),(b), and (h)of this Rule, the report shall cover a calendar year or the portion of a calendar year during which the NF and ICF-MR participated in the medical assistance program. ODJFS shall issue the cost report forms; or appropriate software; or an approved list of vendors for an electronically submitted equivalent; to NFs and ICFs-MR no later than sixty days

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prior to the initial due date of the cost report. For reporting purposes NFs and ICFs-MR, other than state operated facilities, shall use the chart of accounts for NFs and ICFs-MR as set forth in Rule 5101:3-3-201 of the Administrative Code, or relate its chart of accounts directly to the cost report.

- (1) Cost reports submitted by county and state-operated facilities may be completed on an accrual basis and based upon generally accepted accounting principles unless otherwise specified in Chapter 5101:3-3 of the Administrative Code.

610 Allowable Costs not Reported

OAC 5101:3-3-01 states in part... "Allowable costs" are those costs incurred for certified beds in a facility as determined by the department of job and family services (ODJFS) to be reasonable...and (sic) are also determined in accordance with the following reference material, as currently issued and updated, in the following priority:

- (A) (1) Title 42 Code of Federal Regulations (C.F.R.) Chapter IV (sic);
- (2) The Provider Reimbursement Manual ("Centers for Medicare and Medicaid Services "aka HCFA 15-1); or...

The provider failed to include allowable costs, which we are adding to the provider's reportable costs.

611 Chart of Accounts for Long-Term Care Facilities

OAC 5101:3-3-20.1 states in part..." the Ohio Department of Job and Family Services requires that all facilities file semi-annual cost reports through December 31, 1993, and annually thereafter, to comply with Section 5111.26 of the revised Code. The use of the Chart of Accounts in Table 1 through Table 8 of this Rule is recommended to establish the minimum level of detail to allow for cost report preparation. If the recommended chart of accounts is not used by the provider, it is the responsibility of the provider to relate its chart of accounts directly to the cost report."

612 Nonreimbursable Costs – Unsuccessful Lawsuits

OAC 5101:3-3-89 states in part...

The following costs are not reimbursable to ICFs-MR through the prospective reimbursement cost reporting mechanism. except as otherwise specified under Chapter 5101:3-3 of the Administrative Code, nonreimbursable (sic) costs include but are not limited to:

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- (H) Costs associated with lawsuits filed against the Ohio Department of Job and Family Services which are not upheld by the courts.

Adjustments were made per audit to remove costs associated with lawsuits filed against the department but were not upheld in court.

613 Direct Billed Items – Pharmaceuticals

Ohio Administrative Code (OAC) Rule 5101:3-3-19, relationship of other covered Medicaid services to nursing facilities (NFs) and intermediate care facilities for the mentally retarded (ICFs-MR) services states in part:

"This Rule identifies covered services generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism," the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable.

(D) Pharmaceuticals

- (1) Over-the-counter drugs not listed in the "Ohio Medicaid Drug Formulary, 2 - Drugs for which prior authorization was requested and denied, and nutritional supplements are reimbursable only through the facility cost-report mechanism.
- (2) All other pharmaceuticals which either are listed in the "Ohio Medicaid Drug Formulary." or for which prior authorization was requested and approved, are reimbursable directly to the pharmacy provider for residents of NFs and ICFs-MR. Services reimbursable directly to the pharmacy provider are subject to the following conditions:
 - (a) Drug amounts must be dispensed not to exceed maximum prescription quantities established by the Ohio Department of Job and Family Services (ODJFS).
 - (b) Refill dates must be maintained with the original prescription record. Refills are limited to eleven times or one year, whichever comes first, for nonscheduled drugs; five times or six months, whichever comes first, for Schedule III, IV and V drugs; and none for Schedule II drugs
 - (c) For chronic maintenance medications, the pharmacy provider may only bill for one dispensing fee per medication per month.
 - (d) When new prescriptions are necessary following expiration of the last

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refill, the new prescription may be ordered only after the physician examines the patient.

- (e) A copy of all records regarding prescribed drugs for all patients must be retained by the dispensing pharmacy for at least six years. A receipt for drugs delivered to a NF or an ICF-MR must be signed by the facility representative at the time of delivery and a copy retained by the pharmacy."

614 Cost of Ownership – Capitalized Items Expensed

Ohio Administrative Code (OAC) Rule 5101:3-3-84.1, Capital Asset and Depreciation Guidelines, Intermediate Care Facilities for the Mentally Retarded (ICFS-MR) states in part...

- (B) For purposes of determining if an expenditure should be capitalized, the following guidelines are utilized:

- (1) Any expenditure for an item that costs five hundred dollars or more and has a useful life of two or more years per item must be capitalized and depreciated over the asset's useful life.
- (2) A provider may use a capitalization policy less than five hundred dollars per item, but is required to obtain prior approval from the Ohio Department of Job and Family Services (ODJFS) if the provider wishes to change its capitalization policy from its initial capitalization policy.

Adjustments were made to maintain the minimum capitalization policy exhibited by the provider.

615 Nonextensive Renovation – General Criteria (NF) After June 30, 1993

OAC Section 5101 :3-3-84.3 states in part...

- (C) For projects started after June 30, 1993, the following shall apply in order to determine if a project qualifies as a nonextensive renovation:

- (1) The project results in the betterment, improvement, or restoration of an ICF beyond its current functional capacity through a structural change that costs at least five hundred dollars per bed.
- (2) When applying the five hundred dollars per bed requirement the following must apply:

- (a) If the project affects only the Medicaid certified part of the facility, all

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Medicaid beds in the facility will be considered when applying the minimum cost criteria; or

- (b) If the project affects the entire facility, all licensed beds will be considered when applying the minimum cost criteria; and
- (3) The project does not increase the number of licensed beds; and
- (4) If the facility relocates beds within the current structure of the building, the construction for the relocated beds shall be considered a nonextensive renovation if it meets the other criteria specified in Paragraph (C) of this Rule unless the project meets the definition of extensive renovation as defined under the Rule 5101:3-3-01 of the Administrative Code; and
- (5) The ICF-MR has obtained prior approval under Paragraph (E) of this Rule; and
- (6) The ICF-MR has satisfied all requirements for notice to Ohio Department of Job and Family Services (ODJFS) upon completions of the project as set forth under Paragraph (G)(1) of this Rule; and
- (7) Unless the project is necessary to meet the requirements of federal, state or local statutes, ordinances, Rules or polices, ODJFS will not approve a project as a nonextensive renovation if fewer than five years have elapsed since the date of licensure of the portion of the ICF-MR that is proposed to be renovated.

616 Personal Needs Allowance

OAC Section 5101:3-3-09 states in part...

- (A) Each Medicaid resident who receives care in an LTCF certified to participate in the Medicaid program is eligible to retain thirty dollars a month for the purchase of items and services of his or her choice. This personal needs allowance is the exclusive property of the resident to use as he or she chooses to meet personal needs. These funds cannot be used to pay for items and services provided by the LTCF which are covered by the Medicaid program.
- (K) In considering the appropriate use of the personal needs allowance, one must first determine whether the cost incurred is for items or services otherwise covered in the Medicaid program. relative to services provided by the LTCF, the cost of all items or services required to be provided by the LTCF under the conditions of participation are reimbursable only through the ODJFS payment system. The second point to consider in determining the appropriate use of personal needs allowance

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money is whether the purchases were made according to the resident's wishes. If a resident clearly expresses a desire for a particular brand of item not available from the LTCF, then personal needs allowance funds may be used so long as an item of reasonable quality is available to the resident at no charge. Following are some examples of appropriate and inappropriate uses for personal needs allowance monies. The examples are not all inclusive but are to be used as guidelines in determining the appropriateness of an expenditure.

- (1) Some appropriate uses of personal needs allowance funds are: church donations; cigarettes; gifts for resident's friends or relatives; hair care by barbers and cosmetologists; hair care products used for bleaching, coloring, straightening, and permanent waving; life insurance premiums; liquor; newspapers; personal clothing; radio or television in resident's room; stationery and stamps; admission costs or fees associated with out-of-facility activities; burial plots; and dry-cleaning.
- (2) Some examples of inappropriate uses of personal needs allowance funds are: personal laundry charges; nursing supplies; surgical dressings; dietary supplies; irrigation trays; catheters, disposable under pads or diapers; drainage bags; syringes and needles; durable medical equipment; air conditioner; therapy services; podiatry services; room furnishings; soap; combs; toothbrushes, toothpowder, toothpaste, or mouthwash; shampoo; tissues; charges to resident for the use of electricity.

617 Cost of Property and Equipment – Straight Line Depreciation

Ohio Administrative Code (OAC) Rule 5101:3-3-51.1, Capital Assets and Depreciation Guidelines; Nursing Facilities (NFS) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, NFs shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

618 Cost of Ownership – Reimbursed by Government Agency

Ohio Administrative Code (OAC) Rule 5101:3-3-51.2, Cost of Ownership and Efficiency Incentive for Nursing Facilities (NFS) states in part...

"The desk-reviewed, actual, allowable, per diem cost of ownership established in this Rule is subject to the provisions set forth under Rule 5101:3-3-51 of the Administrative Code. The costs of ownership directly attributable to the purchase, rent, or lease of

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property and equipment costs from one related party to another through common ownership or control as defined under Rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase, rent, or lease of property and equipment costs or the actual costs of the related party.

(A) The desk-reviewed, actual, allowable, per diem cost of ownership is based upon certified beds for property costs and equipment set forth under Paragraphs (A)(1) to (a)(3) of this Rule for the calendar year preceding the fiscal year in which the rate will be paid, except as otherwise specified under Rules 5101:3-3-515, 5101:3-3-516, and 5101:3-3-53 of the Administrative Code. The desk-reviewed, actual, allowable, per diem cost of ownership includes:

(1) The costs of ownership directly related to purchasing or acquiring capital assets include:

(E) Depreciation expense for costs paid or reimbursed by any government agency, if that part the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period." adjustments were made to eliminate capital costs on items for which ODJFS has financed. These costs are considered outside the parameters of the cost report mechanism.

619 Cost of Property and Equipment – Depreciation Expense on Capitalized Items

Ohio Administrative Code (OAC) Rule 5101:3-3-51.1, Capital Asset and Depreciation Guidelines; Nursing Facilities (NFS) states in part:::~::~:

(C) All capital assets shall be depreciated using the straight-line method of depreciation

(D) For purposes of determining the useful life of a capital asset, NFs shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

Adjustments were made to recognize depreciation expense on items capitalized during the audit.

620 Renovations – Cost Overruns

Ohio Administrative Section 5101:3-3-51.3 states in part:

(F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

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- (2) The actual cost of construction of the approved cost by the greater of five percent or twenty thousand dollars." the provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

621 Renovations – Change in Plan

Ohio Administrative Section 5101:3-3-51.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

- (5) Any change in the scope of the nonextensive renovation project." the provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

622 Nonextensive Renovations – Rate of Interest

Ohio Administrative Code Section 5101:3-3-51.3 states in part...

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur

- (4) The actual interest rate expense exceeds the projected interest rate by two percentage points or more."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

623 Nonextensive Renovation – Amount Financed

Ohio Administrative Section 5101:3-3-51.3 states in part...

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:

- (3) The actual amount financed exceeds the approved amount financed by greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

624 Personal Needs Allowance

OAC Section 5101:3-3-09 states in part...

- (A) Each Medicaid resident who receives care in an LTCF certified to participate in the Medicaid program is eligible to retain thirty dollars a month for the purchase of items and services of his or her choice. This personal needs allowance is the exclusive property of the resident to use as he or she chooses to meet personal needs. These funds cannot be used to pay for items and services provided by the LTCF which are covered by the Medicaid program.

- (K) In considering the appropriate use of the personal needs allowance, one must first determine whether the cost incurred is for items or services otherwise covered in the Medicaid program. relative to services provided by the LTCF, the cost of all items or services required to be provided by the LTCF under the conditions of participation are reimbursable only through the ODJFS payment system. The second point to consider in determining the appropriate use of personal needs allowance money is whether the purchases were made according to the resident's wishes. If a resident clearly expresses a desire for a particular brand of item not available from the LTCF, then personal needs allowance funds may be used so long as an item of reasonable quality is available to the resident at no charge. Following are some examples of appropriate and inappropriate uses for personal needs allowance monies. The examples are not all inclusive but are to be used as guidelines in determining the appropriateness of an expenditure.
 - (1) Some appropriate uses of personal needs allowance funds are: church donations; cigarettes; gifts for resident's friends or relatives; hair care by barbers and cosmetologists; hair care products used for bleaching, coloring, straightening, and permanent waving; life insurance premiums; liquor; newspapers; personal clothing; radio or television in resident's room; stationery and stamps; admission costs or fees associated with out-of-facility activities; burial plots; and dry-cleaning.

 - (2) Some examples of inappropriate uses of personal needs allowance funds are: personal laundry charges; nursing supplies; surgical dressings; dietary supplies; irrigation trays; catheters, disposable under pads or diapers; drainage bags; syringes and needles; durable medical equipment; air conditioner; therapy services; podiatry services; room furnishings; soap; combs; toothbrushes, toothpowder, toothpaste, or mouthwash; shampoo; tissues; charges to resident for the use of electricity.

625 Cost of Property and Equipment – Straight Line Depreciation

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Ohio Administrative Code (OAC) Rule 5101:3-3-84.1, Capital Asset and Depreciation Guidelines; Intermediate Care Facilities (ICFS-MR) states in part:

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, ICFS-MR shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

An adjustment was made per audit to recognize the provider's depreciation expense on a straight-line basis.

626 Cost of Ownership – Reimbursed by Government Agency

Ohio Administrative Code (OAC) Rule 5101:3-3-84.2, Cost of Ownership and Efficiency Incentive for Intermediate Care Facility for the Mentally Retarded (ICFS-MR) states in part...

"the desk-reviewed, actual, allowable, per diem cost of ownership established in this Rule is subject to the provisions set forth under Rule 5101:3-3-84 of the Administrative Code. The costs of ownership directly attributable to the purchase, rent, or lease of property and equipment costs from one related party to another through common ownership or control as defined under Rule 5101:3-3-01 of the Administrative Code shall be based upon the lesser of the actual purchase, rent, or lease of property and equipment costs or the actual costs of the related party.

- (A) The desk-reviewed, actual, allowable, per diem cost of ownership is based upon certified beds for property costs and equipment set forth under Paragraphs (A)(1) to (A)(3) of this Rule for the calendar year preceding the fiscal year in which the rate will be paid, except as otherwise specified under Rules 5101:3-3-845, and 5101:3-3-86 of the Administrative Code. The desk-reviewed, actual, allowable, per diem cost of ownership includes:

- (1) The costs of ownership directly related to purchasing or acquiring capital assets include:
 - (e) Depreciation expense for costs paid or reimbursed by any government agency, if that part of the prospective per diem rate is used to reimburse the government agency and a loan provides for repayment over a time-limited period."

Adjustments were made to eliminate capital costs on items for which ODJFS has financed. These costs are considered outside the parameters of the cost report mechanism.

NARRTEXT

627 Cost of Property and Equipment – Depreciation expense on Capitalized Items

Ohio Administrative Code (OAC) Rule 5101:3-3-84.1, Capital Asset and Depreciation Guidelines; Intermediate Care Facilities (ICFS-MR) states in part...

- (C) All capital assets shall be depreciated using the straight-line method of depreciation.
- (D) For purposes of determining the useful life of a capital asset, ICFS-MR shall use the table as set forth in Appendix A of this Rule or a different useful life if approved by ODJFS. If a capital asset is not reflected on the table as set forth in Appendix A of this Rule, the internal revenue guidelines shall be used for purposes of determining the useful life of that capital asset.

Adjustments were made to recognize depreciation expense on items capitalized during the audit.

628 Renovations – Cost Overruns

Ohio Administrative Section 5101:3-3-84.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (2) The actual cost of construction of the approved cost by the greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

629 Renovations – Change in Plan

Ohio Administrative Section 5101:3-3-84.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (5) Any change in the scope of the nonextensive renovation project.
the provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

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630 Nonextensive Renovations - Rate of Interest

Ohio Administrative Code Section 5101:3-3-84.3 states in part...

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (4) The actual interest rate expense exceeds the projected interest rate by two percentage points or more."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

631 Nonextensive Renovation - Amount Financed

Ohio Administrative Section 5101:3-3-84.3 states in part:

- (F) Additional notice to ODJFS is required during the course of construction of the approved nonextensive renovation if any of the approved nonextensive renovation if any of the following circumstances occur:
 - (3) The actual amount financed exceeds the approved amount financed by greater of five percent or twenty thousand dollars."

The provider failed to notify the department of this situation, consequently an adjustment was made reclassify the additional unapproved renovation costs to cost of ownership.

632 Direct Billed Items – Podiatry Services

OAC Section 5101:3-3-19 states in part..." Generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable."

- (K) Podiatry services. covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Chapter 5101: 3-7 of the Administrative Code. Payment by the ODJFS is limited to one visit per month for residents in a NF or ICF-MR setting.

633 Personal Needs Allowance

OAC Section 5101:3-3-09 states in part...

NARR TEXT

- (A) Each Medicaid resident who receives care in an LTCF certified to participate in the Medicaid program is eligible to retain thirty dollars a month for the purchase of items and services of his or her choice. This personal needs allowance is the exclusive property of the resident to use as he or she chooses to meet personal needs. these funds cannot be used to pay for items and services provided by the LTCF which are covered by the Medicaid program.
- (I) In considering the appropriate use of the personal needs allowance, one must first determine whether the cost incurred is for items or services otherwise covered in the Medicaid program. Relative to services provided by the LTCF, the cost of all items or services required to be provided by the LTCF under the conditions of participation are reimbursable only through the ODJFS payment system. the second point to consider in determining the appropriate use of personal needs allowance money is whether the purchases were made according to the resident's wishes. If a resident clearly expresses a desire for a particular brand of item not available from the LTCF, then personal needs allowance funds may be used so long as an item of reasonable quality is available to the resident at no charge. following are some examples of appropriate uses for personal needs allowance monies. The examples are not inclusive but are to be used as guidelines in determining the appropriateness of an expenditure.
- (1) Some appropriate uses of personal needs allowance funds are: church donations; cigarettes; gifts for resident's friends or relatives; hair care by barbers and cosmetologists; hair care products used for bleaching, coloring, straightening, and permanent waving; life insurance premiums; liquor; news papers; personal clothing; radio or television in resident's room; stationery and stamps; admission costs or fees associated with out-of-facility activities; burial plots; and dry-cleaning.
- (2) Some examples of inappropriate uses of personal needs allowance funds are: personal laundry charges; nursing supplies; surgical dressings; dietary supplies; irrigation trays; catheters, disposable under pads or diapers; drainage bags; syringes and needles; durable medical equipment; air conditioner; therapy services; podiatry services; room furnishings; soap; combs; toothbrushes, toothpowder, toothpaste, or mouthwash; shampoo; tissues; charges to resident for the use of electricity.

634 Total Inpatient Days

Medicaid days (per ODJFS vendor payment system) will be used in determining the amount paid and amount due the facility in the report of final settlement.

The total inpatient days, as reported by the provider, appear to be correctly stated and will be used in the final settlement rate calculation.

NARR TEXT

900 Cost of Meals for Other than Provider Personnel

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2105.2 states ... " the cost of meals for other than provider personnel, whether served in a cafeteria, coffee shop, canteen, etc., is unallowable under the program because it is not related to patient care (see ~2102.3). Providers must maintain adequate cost data in order to determine the cost of these meals (see ~2300ff).

901 Members of Organizations having Arrangements with Provider – Nonpaid Workers

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 704.5 nonpaid workers must be members of an organization of nonpaid workers that has arrangements with the provider for the performance of services by nonpaid workers. Membership in the organization must be substantiated by adequate documentation in the files of the organization of nonpaid workers. There must exist a legally enforceable agreement between the provider and the organization of nonpaid workers establishing the obligation to remunerate the organization for services to be rendered. however, a legally enforceable agreement would not exist where the provider's legal obligation to pay the organization of nonpaid workers is nullified by an offsetting legal obligation by the organization of nonpaid workers to pay or make a contribution to the provider of all or part of the salary liability. The part of the provider's obligation required to be paid by the organization of nonpaid workers would not be allowed.

A legally enforceable agreement must include the following: the amount applicable to the value of services rendered by nonpaid workers, types of services, the title of each full-time position, number of hours, rates of pay (including salary, fringe benefits, perquisites, and maintenance); the period of time during which services are rendered, the time period in which payment for the services may be made (payment may not be made later than the end of the provider's cost reporting period following the reporting period during which the services are rendered); and the requirement that a provider must maintain proper records as outlined in ~704.8.

Bona fide payment of the provider's obligation to discharge its liability under the legally enforceable agreement will be deemed made to the organization of nonpaid workers when the provider makes payment equal to the net imputed value (see ~704.3) in one of the following ways:

- A. Makes payment by check or cash to the organization of nonpaid workers.
- B. Issues a negotiable instrument (note) to the organization.
- C. Legally transfers assets, such as stocks, bonds, real property, etc., to the

NARR TEXT

organization. The amount of payment will be based on the fair market value of the assets transferred. Such value shall be determined at the time of transfer.

- D. Accepts a written statement from the organization of nonpaid workers disclosing that the organization is voluntarily donating to the provider a part or all of the salary liability, makes the proper book entries, and retains in its files documentation to substantiate the donation and its nature.

The organization of nonpaid workers must obtain a tax exempt status from the u. S. Internal revenue service.

902 Nonallowable Costs –Luxury Items or Services

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2104.3

- A. General - Where provider operating costs include amounts that flow from the provision of luxury items or services, such amounts are not allowable in computing reimbursable costs.
- B. Definitions - Luxury items or services are those that are substantially in excess of or more expensive than the usual items or services rendered within a provider's operation to the majority of patients. This provision should not be confused with the other provision dealing with limitations on coverage of costs as referenced in Paragraph 2104.3(e).
 - (1) Luxury room accommodations...
 - (2) Luxury food items...
- C. Application.- Once it has been determined that luxury items or services have been furnished, allowable cost of luxury items or services will be reduced by the actually furnished and reasonable cost of the usual less expensive items or services furnished by a provider to the majority of its patients.

(See 2106.1 for the proper handling of full cost of items or services where telephone, television, and audio which are furnished solely for the personal comfort of the patient).

903 Nonallowable Costs – Cost of Telephone, Television, and Radio

NARRTEXT

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2106.1 General.- The full costs of items or services such as telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of the patients (full costs include costs both directly associated with personal comfort items or services plus an appropriate share of indirect costs) are not includable in allowable costs of providers under the Medicare program. To illustrate, the full costs of telephones used solely for the personal comfort of patients include not only costs directly associated with these telephones, such as the rates billed by the public utility, but also an appropriate share of indirect telephone costs, e.g., operators' salaries, equipment, space-related costs of switchboard and other equipment, etc., as well as any other overhead that may be applicable thereto. The costs of television and radio services are includable in allowable costs where furnished to the general patient population in areas of providers other than patient accommodations--e.g., day rooms, recreation rooms, waiting rooms, etc.

The cost of a nurse-patient communication system that has capability for other than communications between patient and nurse (or other facility employees) are includable in allowable costs. Similarly, costs of closed circuit television monitoring systems used by providers for surveillance of patients or for security, teaching, or demonstration programs which serve purposes of patient care or which are otherwise needed for the provider's operations and have no capability beyond these stated purposes are includable in allowable costs.

The cost of television and radio located in lounges and other areas designated for the use of provider employees is includable in allowable costs.

904 Nonallowable Costs – Transfer of Assets to a Corporation

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 2134.11 states in part...Costs connected with the transfer of assets to a corporation must be capitalized as part of the cost of the asset (see ~104.10). The acquisition of capital stock of a provider does not constitute a transfer of assets to a corporation and, therefore, costs associated with such a transaction are not allowable.

905 Direct Billed Items – Physician Services

OAC Section 5101:3-3-11 states in part..."Generally available to Medicaid recipients and describes the relationship of such services to those provided by the LTCF. whenever reference is made to reimbursement of services through the facility cost report mechanism, the provisions governing such reimbursement as set forth in Rules 5101:3-3-17 to 5101:3-3-25 of the Administrative Code are applicable."

F. Physician services all covered diagnostic and treatment services provided by a physician are reimbursable directly to the physician. Physician review of medical

NARR TEXT

records and the patient plan of care independent of direct service provision is reimbursable to the facility (reference Rule 5101:3-3-17 of the Administrative Code). Services reimbursable directly to the physician are subject to the following conditions: (1) physician's services must be based on medical necessity and the patient's request for services, except that:

- (a) For SNF patients, a physician visit is required at least once every thirty days for the first ninety days following admission, subsequent to the ninetieth day following admission, an alternate schedule for visits may be adopted where the attending physician determines and so justifies in the patient's medical record that the patient's condition does not necessitate visits at thirty-day intervals. An alternate plan cannot exceed sixty days between visits, nor is an alternate plan permitted for patients under an active specialized rehabilitation plan (reference Rule 5101:3-3-05 of the Administrative Code). These patients must be seen by a physician every thirty days. When an alternate plan is appropriate, the attending physician must notify the facility's UR committee so that the patient's need for monthly physician visits and continued stay can be promptly reviewed. The UR committee may deny the alternate plan.
 - (b) For ICF patients, the physician must visit the patient at least once every sixty days unless the physician decides that this frequency is unnecessary and records the reasons for that decision.
- (2) When a physician performs billable diagnostic or treatment services, entries must be made in the patient's record in the LTCF to document the symptoms and findings. Each such entry must be signed and dated by the physician.
 - (3) When a physician performs medical record or plan of care review independent of service provision, the date of such review must be entered in the patient's medical record or plan of care and any pertinent finding or changes in orders noted. Each such entry must be signed and dated by the physician.
 - (4) Physician visits are limited to four per month! In a nursing home setting. Six additional visits can be made up to a maximum of ten per month if prior authorization is obtained from the department.

906 Direct Billed Items – Transportation Services

OAC Section 5101:3-3-19 states in part..."Generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable."

- (1) Transportation services - Costs incurred by the facility for transporting patients

NARRTEXT

by means other than ambulance or ambulette services are reimbursable through the facility cost reporting mechanism. Payment is made directly to authorized providers for covered ambulance and ambulette services as set forth in Chapter 5101:3-15 of the Administrative Code.

907 Direct Billed Items – Vision Care Services

OAC Section 5101:3-3-19 states in part..."Generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable.

(J) Vision care services

All covered vision care services, including examinations and dispensing and fitting of eyeglasses, are reimbursed directly to authorized vision care providers in accordance with Chapter 5101: 3-6 of the Administrative Code.

908 Direct Billed Items – Podiatry Services

OAC Section 5101:3-3-19 states in part..."Generally available to Medicaid recipients and describes the relationship of such services to those provided by a NF or an ICF-MR. Whenever reference is made to reimbursement of services through the "facility cost report mechanism", the provisions governing such reimbursement as set forth in Chapter 5101:3-3 of the Administrative Code are applicable."

(K) Podiatry Services.

Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Chapter 5101: 3-7 of the Administrative Code. Payment by the ODJFS is limited to one visit per month for residents in a NF or ICF-MR setting.

909 Franchise Tax Adjustment – Minimum Tax

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2122.4 states in part..."A franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. Where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

NARRTEXT

- A. Where a provider has no net income but is required to pay a minimum franchise tax, the franchise tax is an allowable cost.

910 Franchise Tax Adjustment – Net Income less than Minimum Tax

Regulation 2122.4 of the CMS Publication 15-1 (aka) HIM -15 Health Insurance Manual states in part... "A franchise tax is a periodic assessment levied by a state or local taxing authority on the operation of a business within the borders of that governmental entity. The basis used to compute the amount of the franchise tax varies among taxing authorities. Where the amount of the franchise tax is based upon the net income of the provider, with a minimum amount stated, the following criteria will be used to determine whether and in what amount a franchise tax is an allowable cost".

- B. Where a provider realized net income which is not sufficient to incur a tax in excess of the minimum tax and the minimum tax is levied, then only the difference between the minimum franchise tax and the tax computed on net income is an allowable cost. For example, if the minimum tax is \$500 and the tax computed on net income is \$400, then the \$400 is an income tax and only the excess (\$500 – \$400) or \$100 is an allowable cost.

911 Income Tax Adjustment – Federal and Excess Profit

Regulation 2122.2 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."Certain taxes which are levied on providers are not allowable costs. These taxes are:

- A. Federal income and excess profit taxes, including any interest or penalties paid thereon."

912 Income Tax Adjustment – State or Local

Regulation 2122.2 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."Certain taxes which are levied on providers are not allowable costs. These taxes are:

- B. State or local income and excess profit taxes."

913 Income Tax Adjustments – Exemptions

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2122.2 states in part..."Certain taxes which are levied on providers are not allowable costs. These taxes are:

- D. Taxes from which exemptions are available to the provider."

NARR TEXT

914 Income Tax Adjustment – Levied Against Patient

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2122.2 states in part..."Certain costs which are levied on providers are not allowable costs. These taxes are:

- G. Taxes, such as sales taxes, levied against the patient and collected and remitted by the provider."

915 Life Insurance Premiums

Regulation Section 2130 of the CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part ..."In general, premiums related to insurance on the lives of owner(s), officer(s), key employee(s) and provider-based physician(s) where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured individual, the insurance proceeds are payable directly to the provider. A provider is an indirect beneficiary when another party receives the proceeds of a policy through an assignment by the provider to the party or other legal mechanism but the provider benefits from the payment of the proceeds to the third party.

An exception to these requirements is permitted where (1) a provider as a requirement of a lending institution must purchase insurance on the life of an owner(s), officer(s), key employee(s) or provider-based physician(s) to guarantee the outstanding loan balance (2) the lending institution must be designated as the beneficiary of the insurance policy, and (3) upon the death of the insured, the proceeds will be used to pay off the balance of the loan. The insurance premiums allowable are limited to premiums equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and meet the necessary and proper requirements of Section 200ff, interest expense. Where other than decreasing term policies are purchased (e.g., whole life, or convertible term), only that portion of the premium which can be equated to the premium for a similar face amount of a decreasing term life policy may be included in allowable costs.

The life insurance premiums allowable are reimbursable for cost reporting periods beginning on or after April 15, 1983.

Premiums related to insurance on the lives of owner(s), key employee(s) and provider-based physician(s) where the individual relative(s) or his/her estate is the beneficiary are considered to be compensation to the individual and are allowable costs to the extent such total compensation is reasonable.

916 Related Party Organizations – Loans from or Between Owners (Prior to 7/1/66)

NARR TEXT

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual Section 1210. B. Loans subtracted from assets in computing equity capital.-debts representing loans from owners or related organizations made before July 1,1966, are subtracted from assets where the terms and conditions of payment have not been modified subsequent to June 30,1966.

Transferable debenture bonds issued to owners as evidence of loans are treated as though they were issued to nonowners and are subtracted in determining the provider's equity capital. However, nontransferable debenture bonds issued to the owners are treated as loans from owners in accordance with Chapter 2.

917 Interest Paid Mother House or other Governing Body of a Religious Order

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 220. Providers owned and operated by members of religious orders often obtain funds through loans from the mother house or governing body of the religious order. Where there is a contractual agreement for the payment of interest, and for the eventual repayment of the loan, the interest expense is allowable as cost provided the interest is applicable to the period after the certification of the institution as a provider. Interest expense incurred during a reporting period must be paid within the succeeding reporting period.

918 Total Inpatient Days

Per Section OAC 5101:3-3-92 states, For recipients in certified LTCFs, reimbursement may be made to reserve a bed for not more than thirty days in any twelve-month period for any combination of hospital stays or visits with friends or relatives or participation in therapeutic programs. Reimbursement for these days for ICFs, SNFs and ICF/SNFs is fifty per cent of the per diem rate. Reimbursement for these days for ICFs/MR is one hundred per cent of the per diem rate.

919 Administrative Costs Incurred after Provider Terminates Participation in Program

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2176 When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see health insurance Regulations Section 405.626), Administrative costs associated with the preparation and settlement of cost reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct Administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable. Examples of allowable direct Administrative costs are salaries and those costs associated with such salaries, i.e., fringe benefits, workmen's compensation insurance, and payroll taxes; accounting and legal fees which are incurred for bill preparation, bill processing, and cost report preparation; and, where applicable, hearing fees and expenses incurred for settlement with an intermediary and other third parties (see exception below). However, legal fees and related costs incurred

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in the sale of the facilities, costs incurred on or after the effective date of termination for the operation or maintenance or closing of the facility are not allowable. (see ~2414.2b for patient care services rendered after the effective date of termination and ~132a for gains or losses incurred on the disposal of depreciable assets within 1 year after the date of termination.)

920 Deferred Compensation – Formal Plan

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 2140.3. States in part..."The deferred compensation plan must be formal, established and maintained by the provider and communicated to all eligible employees."

921 Compensation – Corporations

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 902.2 for purposes of determining whether the total compensation paid to an owner is reasonable, compensation as defined herein means remuneration paid to an owner regardless of the form in which it is paid. (see ~906 and 906.1.) Compensation may be included in allowable provider cost only to the extent that it represents reasonable remuneration for managerial, Administrative, professional, and other services related to the operation of the facility and rendered in connection with patient care. Services rendered in connection with patient care include both direct and indirect activities in the provision and supervision of patient care, such as administration, management, and supervision of the overall institution. Services which are not related to either direct or indirect patient care, e.g., those primarily for the purpose of managing or improving the owner's financial investment, are not recognized as an allowable cost. Compensation of a physician-owner of a facility is subject to an allocation between professional and provider components (see ~2108).

Payments found to represent a return on equity capital are not compensation and are in no event allowable as an item of reimbursable cost. Nor are such payments considered as compensation for purposes of determining the reasonable level of reimbursement of the owner.

922 Money Borrowed to Fund Depreciation

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 226.5 Borrowed bond reserve and sinking funds are not allowable as funded depreciation, but the interest on such borrowing is allowable subject to the requirements of ~202.1, and income earned by the borrowed funds is applied as a reduction of interest expense"

923 Equity Capital – Excess of Purchase Price Over Allowable Cost

CMS Publication 15-1 (aka) HIM 15 Health Insurance Manual, Section 1215 states; "for facilities or tangible assets acquired after July 1970, the excess of the purchase price paid

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for a facility or asset over (1) the historical cost of the tangible assets, as determined under ~104.10, or (2) the cost basis of the tangible assets, as determined under ~104.14, whichever is applicable, is not includable in the computation of equity capital. Loans made to finance such excess portion of the cost of such acquisitions are similarly not includable in the computation of equity capital."

924 Equity Capital – Liability to Pay Income and Excess Profit Taxes

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1217. The provider's liability to pay federal, state, or local income and excess profit taxes, although unallowable as costs (see ~2122.2), should be included in the computation of equity capital. The tax liabilities to be included in the computation of equity capital computation take into account both current tax liabilities and those liabilities which are deferred due to a difference between the provider's method of accounting for Medicare purposes and the method of accounting used for tax purposes. An asset which results from a current tax overpayment or a difference in accounting method would receive similar treatment.

925 Equity Capital – Funded Depreciation Account

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.3 Where the provider establishes an account in which amounts representing payments received, or amounts accrued, for depreciation expense are deposited, the amounts deposited in this account and the earnings on the funded depreciation which remain in the fund are not includable in equity capital.

926 Equity Capital - Cash Surrender Value of life insurance

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.5 where a provider carries life insurance on officers and key employees, with the provider designated as the beneficiary, the cash surrender value of the policy should be shown as an asset. Any cash surrender value of such insurance is not included in equity capital.

927 Equity Capital – Prepaid Life Insurance

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1218.6 Prepaid premiums on life insurance carried by a provider on officers and key employees, where the provider is designated as the beneficiary, are not included when computing equity capital.

928 Equity Capital - Factors in Calculation

CMS Publication 15-1 (aka) HIM-15 Health Insurance Manual, Section 1220.4

D. Withdrawals by owners - Equity capital is reduced by withdrawals of cash or other assets by owners. These withdrawals may be in the form of reductions of invested

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capital, dividend distributions, payments of personal expenses of owners from the operating funds or other funds related to patient care, or drawings of owner's salary or living expenses not reflected in the profit or loss account. such withdrawals are included in the calculation in the month in which they are made.

- E. Loans from owners - Loans from owners which are considered as invested capital under the provisions of 1210 are included in this category. Loans made are included in the calculation in the month in which they are made and repayments of loans are included in the month in which they are repaid in the "other increases" column.

929 Home Office Costs – General Limitation on Allowability of Costs

CMS Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 2150.1. Where a provider is furnished services, facilities, or supplies from an organization related to it by common ownership or control, the costs allowed are subject to the provisions of Chapter 10. Thus, allowable cost is limited to the lower of (1) allowable costs properly allocated to the provider, except as indicated in ~1010, or (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account of the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chain wide basis.

930 Home Office Costs – Chain Operations

CMS Publication 15-1 (aka HIM-15 Health Insurance Manual, Section 2150. A chain organization consists of a group of two or more health care facilities which are owned, leased, or through any other device, controlled by one organization. chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable, and governmental organizations. A chain organization may also include business organizations which are engaged in other activities not directly related to health care.(see ~1002.2 and 1002.3 for definitions of common ownership and control.)

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and services furnished to the facilities in the chain. The home office of a chain is not a provider in itself; therefore, its costs may not be directly reimbursed by the program. The relationship of the home office to the Medicare program is that of a related organization to participating providers. Home offices usually furnish central management and Administrative services such as centralized accounting, purchasing, personnel services, management direction and control, and other services. To the extent the home office furnishes services related to patient care to a provider, the reasonable cost of such services are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain.

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Very often the home office of a chain organization charges the providers in the chain a management fee for the services the home office furnishes. Management fees charged between related organizations are not allowable costs, except where ~1010 is applicable, and such fees must be deleted from the provider's cost report. However, where management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are includable as allowable costs of the provider. The instructions for preparation of a home office cost statement containing schedules for the determination of home office costs and equity capital, and their allocation, are set forth in ~2153.

Section 2150 is not applicable to franchise fees (see ~2133ff.), management fees or fees for other services paid by a provider where there is no common ownership or control between the provider and the franchisor or other service organization, or where the exception to the related organization principle applies (see 1010).

A. Internal Control

As a part of our examination, we conducted a study of the system of internal control to the extent we considered necessary to evaluate the system. In our opinion, we found the system of internal control to be adequate.

B. Internal Control

As a part of our examination, we have conducted a study of the system of internal control to the extent we considered necessary to evaluate the system. Our study and evaluation would not necessarily disclose all weakness in the system, however, see following narrative for those which we consider to be significant.

C. Accrued Owner's Compensation

Regulation 906.4(a) of the HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part..."General--The compensation of stock-holder-employees and individuals described in ~901 (other than sole proprietors and partners) shall be included for a cost reporting period if earned within the period even if not paid until after the close of the period. However, the actual payment must be made (whether by cash, negotiable instrument, or in kind) within 75 days after the close of the period. If payment is not made within the cost reporting period, or within 75 days thereafter, the unpaid compensation is not includable in allowable costs either in the period earned or in the period when actually paid. For this purpose, an instrument to be negotiable must be in writing and signed, must contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and must be payable to order or to bearer".

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D. Accrued Owner's Compensation

During our audit, we examined the payroll records of the provider to determine that any accrued owner's compensation was paid within seventy- five (75) days after the end of the calendar year. We found nothing to indicate that any accrued wages were not paid within this time frame.

E. Administrative Salary Ceiling

OAC Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR provides for a ceiling of administrator's compensation. Allowable compensation will be determined in final settlement calculation.

We examined payroll records of the provider and determined the compensation reported on the cost report is correctly stated. Our review also did not indicate any reported costs that should be deemed as compensation of administrator. and we wish to extend our appreciation to the administrator and staff for the cooperation we received in performing our examination. fAdministrative salary ceiling

F. Administrative Salary Ceiling

OAC Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR provides for a determination of administrator's allowable compensation. The allowable administrator's compensation will be determined in the provider's final rate recalculation.

We examined payroll records of the provider and determined the compensation for administrator was not properly reported on the cost report and have accordingly adjusted the appropriate cost center.

G. Administrative Salary Ceiling

OAC Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR provides for a determination of the administrator's allowable compensation. allowable compensation will be determined in the provider's final rate recalculation.

Our audit discovered costs that are deemed to be additional compensation for the administrator and has adjusted the administrator's reported compensation, accordingly.

H. Administrative Salary Ceiling

OAC Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR provides for a determination of allowable administrator's compensation. Allowable

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administrator's compensation will be determined in the provider's final rate recalculation.

The supplemental information reported on the C-1 Schedule for administrator and used in computing a salary ceiling per Ohio Administrative Code, Section 5101:3-3-20, for this position appears to be reasonably stated.

I. Administrative Salary Ceiling

OAC Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR provides for a determination of the allowable administrator's compensation. Allowable compensation will be determined in the provider's final rate recalculation.

The supplemental information reported on the C-1 Schedule for administrator and used in computing a salary ceiling per Ohio Administrative Code, Section 5101:3-3-20, for this position appears to be reasonable except as reflected in the revised C-1 Schedule.

J. Owner's Compensation

The supplemental information reported on the C-2 Schedule for compensation of owners and/or relatives (non-administrator positions) and used in computing a salary ceiling per Ohio Administrative Code, Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR, appears to be reasonably stated. Owners' allowable compensation will be determined in the final recalculation of the provider's rates.

K. Owner's Compensation

The supplemental information reported on the C-2 Schedule for compensation of owners and/or relatives (non-administrator positions) was used in computing a salary ceiling per Ohio Administrative Code, pursuant to OAC Rule Sections 5101:3-3-48 for NFs and 5101:3-3-81 for ICFs-MR. The original C-2 information has been adjusted. See revised schedule c-2 included with this report for the correct information. Allowable owners' compensation will be determined in the provider's final rate recalculation.

L. Equity Capital

A review of equity shows the retained earnings balance on equity capital was properly forwarded to beginning of audit period and stated properly for the end of the audit period.

LDA: Dear Provider:

We have performed a desk audit of the Medicaid Cost Report (ODHS

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2524) of the above referenced provider for the period indicated above. This cost report has been prepared on the basis of accounting used for reimbursement under the state of Ohio Medicaid program. the Ohio Administrative Code.

A desk audit consists principally of inquiries of provider personnel and analytical procedures applied to financial data. It is substantially less in scope than a field audit, the objective of which is the expression of an opinion on the Medicaid Cost Report. Accordingly, we do not express such an opinion.

Based on our desk audit, we are not aware of any material modifications, except for the effects, if any, of the adjustments noted in the summary of audit adjustments that should be made to the accompanying Medicaid Cost Report (ODHS 2524) in order for them to conform with reimbursement Rules promulgated by the state of Ohio Medicaid program for the period indicated above.

This report is intended solely for the use of the Ohio Department of Job and Family Services.

Ohio Department of Job and Family Services
Office of External Audits
Bureau of Audit

LFA: Dear Provider:

We have not examined the financial statements of the above referenced provider for the period indicated above and, accordingly, we do not express an opinion on them. However, we have examined the Medicaid Cost report (ODHS 2524), together with any accompanying schedules and exhibits, prepared on the basis used for reimbursement under the State of Ohio Medicaid program for the period indicated above. Our examination was made in accordance with Rule 5101:3-3-21 of the Ohio Administrative Code, and, accordingly, included such tests of the accounting and statistical records and such other auditing procedures as we considered necessary in the circumstances.

Nursing home providers in the state of Ohio are required to prepare their Medicaid Cost Reports (ODHS 2524), and any accompanying schedules

and

exhibits on the basis used for reimbursement under the State of Ohio

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Medicaid program, which in certain respects differ from generally accepted accounting principles. accordingly, the financial statements and information contained in the Medicaid in the Cost Report ODHS 2524) are not intended to present financial position and results of operations in conformity with generally accepted accounting principles.

Audit adjustments, if any, that have been proposed, and their net effect are noted in the attached summary of audit adjustments for the period indicated above. These adjustments are further detailed and explained in the narrative Section of this report. We consider these adjustments necessary to properly present the financial information contained in the Medicaid Cost Report (ODHS 2524).

In our opinion, except for the effects of the adjustments noted in the summary of audit adjustments, the Medicaid Cost Report (ODHS 2524), together with any accompanying schedules and exhibits present fairly the financial information shown therein in conformity with the reimbursement Rules promulgated by the state of Ohio Medicaid program for the period indicated above

This report is intended solely for the use of the Ohio Department of Job and Family Services

Ohio Department of Job and Family Services
Office of External Audits
Bureau of Audit

LUA Dear Provider:

We were engaged to perform a desk audit of the above referenced provider's Medicaid Cost Report (ODHS 2524) for the period indicated above. Desk audits are performed in conformance with standards stated in Section 5111.27, revised Code. A desk audit consists primarily of inquiries of the provider's personal and analytical procedures applied to financial data. Ohio Administrative Code, 5101:3-3-20(n)(3) states:

Refusing legal access to fiscal, statistical, or medical records shall result in a penalty as specified in paragraph (N)(1) of this Rule for outstanding medical services until such time as the requested information is made available to ODJFS program by the date within at least sixty days after request by the state or its subcontractors.

Ohio Administrative Code, 5101:3-3-20(n)(1) which sets forth the associated penalty, states:

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Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages of no more than the greater of one thousand dollars per audit or twenty-five percent of the cumulative amount by which the costs for which documentation was not furnished increased the total Medicaid payments to the provider during the fiscal year for which the costs were used to establish a rate.

Despite requests for access to the records of the provider in order to perform the audit, the records were not made available for performance of the audit. accordingly, we were unable to substantiate the financial or statistical data presented in the provider's Medicaid Cost Report.

This letter is intended solely for the use of the Ohio Department of Job and Family Services

Ohio Department of Job and Family Services
Office of External Audits
Bureau of Audit

M. Equity Capital

Section 1202.1 of the HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual states in part...Equity capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicare/Medicaid program), adjusted for those assets and liabilities which are not related to the provision of patient care.

See revised equity memo included with this report ntotal inpatient days

67 N. Total Inpatient Days

Medicaid days (per ODJFS vendor payment system) will be used in determining the amount paid and amount due the facility in the report of final settlement.

The total inpatient days, as reported by the provider, appear to be correctly stated and will be used in the final settlement rate calculation.

O. Total inpatient days

Per Section 2304 of HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, an adjustment to total inpatient days was made. Provider overstated due to calculation errors in patient census records.

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P. Total Inpatient Days

Per Section 2304 of HCFA Publication 15-1 (aka) HIM-15 Health Insurance Manual, an adjustment to total inpatient days was made. Provider understated due to calculation errors in patient census records.

Q. Total Inpatient Days

Per OAC Section 5101:3-3-03 total inpatient days were adjusted. Provider failed to include allowable Medicaid leave days.

R. Private Pay Rates

We reviewed the non-Medicaid daily room rates and charges for routine services (comparable to Medicaid patients) per OAC Section 5101:3-3-18

(a) The aggregate non-Medicaid rate is shown on the summary page of this report.

S. Private Pay Rates

OAC Section 5101:3-3-18 states in part..."the Medicaid rate is considered the provider's customary charge in all public facilities and when the Medicaid utilization rate for the cost report year exceeds ninety per cent."

SPC

T. Personal Allowance

A review of personal allowance accounts showed that the records were kept in compliance with existing Regulations.

U. Personal Allowance

A review of personal allowance accounts showed that the records were not kept in compliance with existing Regulations.

The following exceptions were noted:

UA A. P.A. funds were commingled with general operating funds

UB B. Negative balances (see list of names and amounts set forth).

UC C. Balances over \$1,500.00 (see list of names and amounts set forth).

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UD D. No support for expenditures

UE E. Inappropriate use of P.A.. funds

V. Home Office Costs

Provider did not report any home office costs.

W. Home Office Costs

Home office costs as reported appear to be reasonably stated.

X. Equity Capital

Section 1201.1 of CMS Publication 15-1 (aka HIM-15 Health Insurance Manual states in part...Equity capital is the net worth of the provider (owners equity in the net assets as determined under the Medicare/Medicaid program). Since the adjustments would not alter reimbursement, we did not adjust for those assets and liabilities which were not related to the provision of patient care.

X1 Dummy for Provider Specific Narrative 1

X2 Dummy for Provider Specific Narrative 2

X3 Dummy for Provider Specific Narrative 3

X4 Dummy for Provider Specific Narrative 4

X5 Dummy for Provider Specific Narrative 5

X6 Dummy for Provider Specific Narrative 6

X7 Dummy for Provider Specific Narrative 7

X8 Dummy for Provider Specific Narrative 8

X9 Dummy for Provider Specific Narrative 9

Y. Home Office Costs

Home office costs were adjusted accordingly, see proposed cost adjustment sheets for adjustments.

Z. Equity Return

Section 1200 of CMS Publication 15-1 (aka HIM 15) states in part... "An allowance of a reasonable return on equity capital invested and used in the provision of patient care is includable as an element of the reasonable cost of covered services furnished to beneficiaries by proprietary providers. The amount allowable on an annual basis is determined by applying to the provider's equity capital the percentage stipulated in S 1206.

Section 1202.4 publication HCFA - 15 (aka HIM 15) states in part... "The term

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proprietary providers means providers, whether sole proprietorships, partnerships, or corporation organized and operated with the exception of earning profit for the owners, as distinguished from providers organized and operated on a nonprofit basis.

We passed on testing the provider's balance sheet as they do not receive a return on equity.