REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Nursing Facility Cost Reporting Study

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 46

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

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Executive Summary

The 2006 Appropriation Act (Chapter 3, Item 302.QQ) requires the Department of Medical Assistance Services (DMAS) to work with representatives of the nursing facility provider associations to develop a revised cost reporting methodology which improves the timeliness and efficiency of the current process and to report to the Governor and Chairmen of the Senate Finance Committee and House Appropriation Committee by September 1, 2006. DMAS is also required to evaluate whether the time savings associated with the enhanced cost reporting process would make feasible the use of more current data in the biannual rebasing of ceilings used in the reimbursement methodology for nursing facility direct and indirect operating costs.

Despite the adoption of electronic technology in some aspects of the cost reporting process, many aspects of the reporting process are paper oriented and time consuming. DMAS and the nursing facility industry are committed to "modernizing" the cost reporting process. Both parties recognize that the adoption and integration of technology in the nursing facility cost reporting process has the potential to produce a more timely, more cost effective, and more efficient cost reporting process.

DMAS convened a workgroup, which has met four times. This report covers the areas studied by the workgroup to date. The report reviews the current cost reporting process in section 2. The report then focuses on three ways to improve the cost reporting process in sections 3, 4, and 5. Finally, the report reviews whether the enhancements would make more current cost report data available for rebasing in section 6.

The first way to improve the cost reporting process is to improve the availability of reports produced by DMAS and used by nursing facilities to prepare cost reports. Although DMAS currently furnishes some data on its web page, these data do not include the facility specific data that are used for cost reporting. The data for cost reporting are produced electronically, but then printed and mailed to providers. While the data is usually mailed timely, it sometimes does not immediately get to the person or persons who need it for preparing the cost report. It then takes additional time and effort to respond to requests for replacement or duplicate copies. This can also delay the nursing facility's preparation of the cost report. The workgroup considered options to either post provider specific reports on the web or e-mail reports to providers. The workgroup will need to make a decision on the most advantageous approach by the end of the year and DMAS will implement it by next July. This will result in small efficiencies at both nursing facilities and for DMAS. DMAS will also work to implement the electronic pre-population of cost reports with the facility specific data, eliminating an additional data entry step by the facility.

The second way to improve the cost reporting process is to improve the cost report submission process. Currently, DMAS provides an electronic Excel spreadsheet

for cost reports with a separate worksheet for every schedule of the cost report. Providers must tab from worksheet to worksheet to enter data. After completing the cost report, providers print the cost report and submit it on paper to DMAS. After reviewing for completeness, DMAS' contractor, Clifton Gunderson, enters the data by hand in DMAS' Oracle cost reporting database.

Nursing facilities want to be able to map data electronically from their own data systems to a single worksheet or "input sheet" in a file that can then automatically pre-populate all the schedules in the cost report. For its part, DMAS wants a standard format it can use to upload data from the electronic spreadsheet to its Oracle database. A single change will accomplish both of these goals. DMAS will implement these enhancements by the end of the year. However, DMAS and the industry are interested in additional enhancements, including automatic validation checks and variance warnings that would speed the completeness review and the actual settlement process. These improvements could be achieved either through an enhanced Excel spreadsheet or through a web-based application. The workgroup will continue to work on these and provide input to DMAS with the goal to implement additional improvements by the end of 2007. DMAS may need additional resources to do this, and if so will request funding.

The third way to improve the cost reporting process is to improve the management of documents. Under the current process, there is a paper file two inches thick on average for each completed desk audit. Utilizing a process or application that allows for the electronic submission of cost report data in a specific predefined format into a centralized database repository is the first step in a paperless cost reporting process. The next step is to review, analyze, and compare submitted cost report data electronically and then store the "file" electronically along with any supporting documentation submitted electronically. Electronic files would improve access to the files by all parties, including field auditors on site. Finally, the use of electronic notifications would speed up communications. The workgroup will need to continue researching document management systems for recommendations by July 2007. There may be some additional up-front costs, but there will also be savings of storage and retrieval costs and printing costs.

Finally, the workgroup discussed the feasibility of using more current data in the biannual rebasing process. The stated goal is to reduce the "look-back" from 3½ to 2½ years. Regulations require that DMAS use the most recent complete database of settled cost reports available in September of the year prior to the effective date of rebasing. This deadline allows DMAS to complete the rebasing calculation in time to include it in its budget request for the coming year. However, most providers have fiscal years ending in December, and the cost reports for the calendar year ending prior to any given September are not initially settled until about three months after the September deadline. This forces the use of cost reports from one full year earlier.

December cost reports are not considered settled until the following November because nursing facilities have five months to file cost reports and DMAS has six months to settle them. For the FY 2007 rebasing, the cost reports to be used had to be settled by September 2005, and at that point the December 2004 cost reports were not yet settled. Therefore, DMAS used 2003 cost reports. The majority of December 2004 cost reports were not settled until three months after September 2005.

Given the September deadline, the filing and settling of cost reports would have to be shortened by three months if the look-back period is to be reduced. Provider representatives have said they would be willing to file cost reports one month earlier if certain conditions are met and if DMAS can commit to shortening the audit process by two months so that the September deadline can be met. At the time of this report, the time savings from anticipated and potential process improvements in cost reporting are too uncertain for DMAS to immediately commit to a reduction of two months. The workgroup will continue to meet, and as process improvements are implemented the parties will evaluate further what can be accomplished.

The additional alternative that is mentioned for sake of completeness is the one that was discussed last year but never acted upon. This would authorize DMAS to apply a 2½ year look-back by using as-filed cost report data to develop its budget request, and then substitute settled data later when calculating final rates. Since DMAS requires that nursing facilities include audited financial statements along with other supporting documentation when they submit their Medicaid cost report, the overall variance in allowable provider cost between as-filed and settled cost report data is historically small and consistent from year to year.

This approach was offered for consideration previously and it must be acknowledged that this method introduces an additional element of uncertainty in the budgeting process. Provider representatives consider this uncertainty to be insignificant from a financial materiality perspective and very consistent when the historic variance is measured.

As should be apparent, this report concerns a work in progress. There remains much work to be done, and many decisions to be made, before the cost reporting process reflects all the changes that the parties intend. DMAS will continue to work with the workgroup to accomplish these changes.

1. Introduction

This study was undertaken to fulfill the following mandate in the 2006 Appropriation Act (Chapter 3, Item 302.QQ).

> *The Department of Medical Assistance Services shall work with representatives of the nursing facility provider associations to develop a revised cost-reporting methodology which improves the timeliness and efficiency of the current process. The Department shall report its finding and recommendations to the Governor and the Chairman of the House Appropriations and Senate Finance Committees by September 1, 2006. A specific goal of such an enhanced process would be to decrease by one year the look-back period used within the biennial cost ceiling rebase determination.*

The department convened a workgroup composed of representatives of the nursing facility industry nominated by the Virginia Health Care Association (VHCA), the Virginia Association of Nonprofit Homes for the Aging (VANHA) and the Virginia Hospital and Healthcare Association (VHHA), representatives from Goodman & Company and Walker Healthcare Services Group, accounting firms specializing in nursing facility cost reports, representatives from DMAS and representatives from Clifton Gunderson and First Health Services Corporation, DMAS contractors for cost settlement and information management. Members of the workgroup are listed in Appendix 1.

The workgroup met on March 29, 2006, May 4, 2006, June 1, 2006 and July 20, 2006. Agendas and minutes from the workgroup meetings are included in Appendix 2.

The report is presented in six major sections. This section discusses the authority of the report and the composition of the workgroup. Section 2 presents an overview of the current cost report process. Section 3 discusses improving the availability of reports used by nursing facilities in cost reporting. Section 4 offers ways to improve cost report submission. Section 5 provides information about improving the management of documents. Section 6 discusses the history and methodology used to rebase ceilings, including a description of the time period between the base year data used for rebasing rates and the first year to which the new rate will be applied, commonly referred to as the "look-back" period.

Currently, approximately 275 nursing facilities submit annual cost reports to DMAS at the end of the provider fiscal year. Clifton Gunderson, the DMAS contractor for cost settlement, audits the cost reports and uses the cost reports to establish the prospective rate for the next provider fiscal year. DMAS uses cost data in the biannual rebasing and for various analyses and budget estimates.

Despite the adoption of electronic technology in some aspects of the cost reporting process, the current cost reporting process is paper oriented. DMAS and representatives of the nursing facility industry recognize that the adoption and integration of technology in the nursing facility cost reporting process has the potential to produce a more timely, more cost effective, and more efficient cost reporting process. Technology is now available for improvements and enhancements desired by DMAS and the nursing facility industry in Virginia. Data uploads and downloads can be designed that eliminate redundant data entry. Developing standard protocols and examining best practice models have the potential to generate greater efficiencies, more timely delivery of settlement and audit reports, and increased effectiveness in data analysis. Use of these innovations for cost reports can lead to increased ease-of-use and a greater acceptance of computer-based interventions. These interventions may provide an increased adoption of electronic communication and computer-based technologies. Advances can also lead to systems that are more helpful in decision-making, and in turn will lead to more sophisticated decision support/workflow management and greater availability and use of benchmarks.

Two examples illustrate the limitations of the current process and its failure to maximize the use of technology to streamline the cost reporting process. In the first example, DMAS provides cost report forms on an Excel spreadsheet, which is available on the DMAS web site. Providers use this spreadsheet or a similar spreadsheet to complete the cost report, but then print the completed file and send in a paper copy of the cost report. Therefore, even though the cost report has been prepared electronically, Clifton Gunderson still must enter data from the paper cost report into DMAS' cost reporting database by hand prior to beginning its audit. In the second example, First Health, the DMAS fiscal agent, produces MMR-240 electronic reports with information on Medicaid days, charges, and payments from the Medicaid Management Information System (MMIS). The reports are produced two months after the end of the provider fiscal year, to be used in the provider's cost report. Instead of sending these reports electronically, Clifton Gunderson currently prints these reports and mails them to providers, who must then key the data manually.

DMAS and the nursing facility industry are committed to "modernizing" the cost reporting process. While this study reports actions to be taken soon, DMAS and the industry also recognize that they have not yet addressed all components of successful implementation, including support, training, ongoing development, etc. or all the potential improvements. DMAS and the industry will continue to work together after the report to implement the recommendations and to identify additional improvements.

Early in the discussion, DMAS and the industry identified the business needs that would guide the work to modernize the cost reporting process.

1.1 Industry Business Needs

1. Streamline cost report preparation recognizing providers have methods/technologies to export data from accounting and financial systems when preparing cost reports.
2. Examine ways to submit online cost report information for all types of reports and supporting schedules.
3. Coordinate/integrate as much as possible Medicaid cost report submission with Medicare cost report data.
4. Improve the ability for multiple staff to access on a timely basis DMAS furnished provider specific data used in cost settlement.
5. Incorporate "Help" Features into cost report supported by offering simple, constructive, and specific instructions.
6. Create a web-based Information Bulletin Board announcing updates or changes in the cost report process.
7. Reduce time to file and settle cost reports so that a $2^{1/2}$ look-back is feasible for rebasing.

1.2 DMAS Business Needs

1. Support cost reporting processes that manage DMAS resources efficiently and effectively.
2. Securely integrate any cost reporting process changes with DMAS' existing Oracle database.
3. Reduce DMAS' time and cost in disseminating CMI and MMR reports.
4. Improve provider compliance with cost reporting requirements and submission of explanation and/or supporting documentation.
5. Provide for comparable data collection/validation to allow for analysis/benchmarking.
6. Automate the production of a database for rebasing and other modeling.
7. Reduce storage of paper documents and streamline document retrieval.

2. Current Cost Reporting Process

Currently, DMAS contracts with Clifton Gunderson to perform specified audit procedures on Medicaid cost reports by applying comprehensive desk and field audit program procedures. Clifton Gunderson's duties consist of managing the cost reporting process, completing a comprehensive Uniform Desk Review, or desk audit, of cost reports received, and determining if further on-site field audit is required, subject to DMAS approval. The focus of this study is primarily on the nursing facility cost report submission and initial desk audit.

Clifton Gunderson is responsible for issuing cost reporting forms to participating providers based on their fiscal year-end (FYE) and monitoring to assure receipt of the cost reports in accordance with the State Plan for Medical Assistance, state regulations, and DMAS policies. Appendix 3 includes current state regulations on nursing facility cost reporting. Clifton Gunderson maintains a tracking system to log receipt of cost reports and verifies the status of reports through completion of desk and field audits. In addition, Clifton Gunderson is responsible for issuing Notice of Program Reimbursement letters (NPR) to providers after desk and field audits.

Clifton Gunderson performs desk audits based on a Uniform Desk Review. The Uniform Desk Review provides for an analysis of the provider's cost report to determine its adequacy and the completeness and reasonableness of data reported. The Uniform Desk Review concludes with a summary of desk audit results to either settle the cost report without field audit or to determine the extent to which field audit is required.

When cost reports are received by Clifton Gunderson, and first entered in a database, they have been certified for accuracy by the nursing facility (and submitted with audited financial statements), but have not yet been desk audited by Clifton Gunderson. Throughout this report, the cost reports that have reached this stage of review will be referred to as "as-filed" cost reports. Clifton Gunderson desk audits all cost reports before they are used to set rates. Throughout this report, the cost reports that have been desk audited by Clifton Gunderson will be referred to as "settled" cost reports.

2.1. Cost Report Submission

Cost reports are due not later than 150 days after the provider's fiscal year-end. A complete cost report must include an audited financial statement and other schedules (See Appendix 4 for a complete list). DMAS increased the number of days for filing of a cost report from 90 to 150 days a number of years ago at the same time that Medicare made that change. When the time frame was 90 days, nursing facilities had additional time to submit the audited financial statements, which frequently were not available 90 days after the fiscal year.

The PIRS 1090 Medicaid cost reporting form is furnished to providers in a Microsoft Excel workbook containing a variety of schedules needed for cost settlement. There are actually two versions of the PIRS 1090, the "Short Form" and the "Long Form". The cost report used by nursing facilities with multi-levels of care is commonly referred to as the PIRS 1090 "Short Form" and captures over 125 separate data elements. The cost report used by single level of care facilities is commonly referred to as the PIRS 1090 "Long Form" and captures 500 separate data elements.

Multi-level facilities are ones that are certified to have Medicare residents. They complete a Medicare cost report, which provides much, but not all the data DMAS needs. The remaining data is reported via the short form. Clifton Gunderson reviews not only the Medicaid cost report but the underlying data, particularly any adjustments, from the Medicare cost report. Since single level facilities do not file a Medicare cost report, they therefore must provide more detailed information via the long form.

The majority of nursing facilities are "freestanding" (not a unit within a hospital). If they are multi-level freestanding facilities, they submit the Medicare 2540 (nursing home) cost report along with the Medicaid cost report. Facilities that are hospital-based submit the Medicare 2552 hospital cost report along with the Medicaid cost report.

The following table provides a side-by-side comparison of the two PIRS 1090 cost reports and data sources needed to complete the cost reports. Total entry counts for each schedule are included.

Table 1: Minimum Data Elements Needed for Cost Settlement

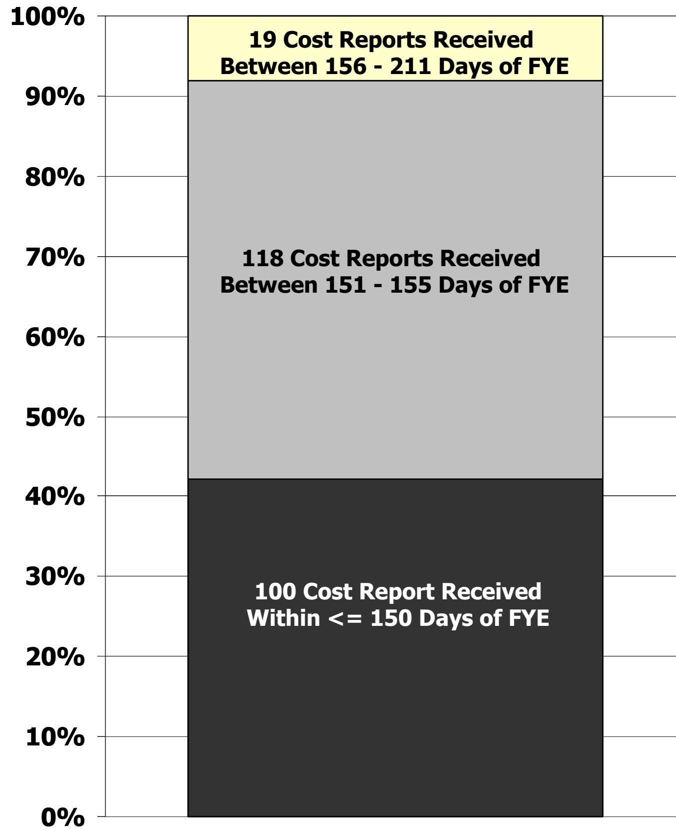
Schedule Description	Total Entries Possible	PIRS 1090 "Long Form "	PIRS 1090 "Short Form"	Sources of Data (Medicare CMS 2540, CMS 2592 or MMR-240)
A-Facility Description and Statistical Data	2	LONG		
B-Reclassification and Adjustment of Trial Balance of Expenses	104	LONG		
B-1-Reclassifications	42	LONG		
B-2-Analysis of Administrative and General Expenses	45	LONG		
B-4-Adjustments To Expenses	153	LONG		
B-5-PTII-Cost Allocation- Employee Benefits	43	LONG		
A-3-Computation of Patient Intensity Reimbursement	2		SHORT	MEDICARE

Table 1: Minimum Data Elements Needed for Cost Settlement

Schedule Description	Total Entries Possible	PIRS 1090 "Long Form "	PIRS 1090 "Short Form"	Sources of Data (Medicare CMS 2540, CMS 2592 or MMR-240)
System Base Operating Costs				
A-4-Computation of Direct Patient Care Nursing Service Costs	13		SHORT	MEDICARE
C-Computation of Title XIX Direct Patient Care Ancillary Service Costs	44	BOTH	BOTH	MEDICARE & MMR-240
H-Computation of Title XIX Base Costs and Prospective Rates/PIRS	2	BOTH	BOTH	MEDICARE & MMR-240
J-Computation of Nursing Facility Medical Service Potential Prospective Reimbursement	4	BOTH	BOTH	
J P-TIII-Settlement Computations	2	BOTH	BOTH	
J-PT-IV-Analysis of Nursing Facility Interim Payments for Title XIX Services	6	BOTH	BOTH	MMR-240
J-PT-V-Analysis of Nursing Facility Title XIX Patient Days	4	BOTH	BOTH	MMR-240
J-PT-VI-Analysis of Nursing Facility Title XIX Charges	1	BOTH	BOTH	MMR-240
J-1-Calculation of NATCEPs Reimbursement Settlement	7	BOTH	BOTH	
J-2-Calculation of Criminal Record Check Costs Reimbursement	2	BOTH	BOTH	
N-PT1-Nurse Aide Training and Competency Evaluation Program Costs and Competency	10	BOTH	BOTH	
N-Part II Total	5	BOTH	BOTH	
N-Part III Total	24	BOTH	BOTH	
Total	515	500	126	

Clifton Gunderson provided statistics on the number of facilities and the time ranges when cost report packages were received. The analysis indicated that of the 238 free-standing cost reports due in 2005, 100 were received within 150 days or less (80 were deemed complete), 119 were received between 151 and 155 days, and 19 were received more than 5 days late (range is 11 to 221 days late). Appendix 5 contains the Completeness Review Checklist.

Figure 1: Statistics on Receipt of Free-Standing Nursing Facilities Cost Reports



2.2 Desk Audit

Clifton Gunderson is responsible for the desk and field audit functions performed by DMAS. Table 2 summarizes standard tasks conducted by Clifton Gunderson to complete a desk audit and the time required for each task to settle a cost report for a multi-level nursing facility.

Table 2: Overview of the Current Cost Report Cycle

	Approximate Time
Cost Reports are due to DMAS' contractor 150 days after Provider fiscal year-end (FYE) and a letter is sent to providers not meeting the 150-day deadline.	¼ hour
Clifton Gunderson initiates a completeness audit. Analysts check if all forms, reports, and schedules are included in the facility's cost report package and other validation/audit functions.	2 ½ - 3 hours
"As-filed" cost report is entered in an Oracle database and a desk audit begins.	1 – 2 hours
An analyst conducts a desk audit, proposes adjustments, applies adjustments, and revises the submitted cost report, as needed, and enters data into the Oracle database. An analyst may contact a provider for additional documentation to answer questions. Included during this portion of the desk audit are various calculations and memos describing the results of the desk audit. If appropriate, analyst may recommend a field audit.	30 – 42 hours
Proposed desk audit is reviewed by a manager.	6 – 12 hours
Desk audit is sent to the facility along with NPR for current year. Regulations require that this be done within 180 days of receipt of a complete cost report.	½ hour

The average amount of time to complete a desk audit depends on the type of provider and the cost report forms they utilize. Some providers are very complex with multiple levels of care available and have 180 beds or more while others may only offer a single level of care and have less than 50 beds. Table 3 displays the average number of settlements and hours needed to complete a desk audit and settlement. Nursing facility cost report settlements are more time intensive than settlements for other providers because of the materiality of data used in a complex reimbursement methodology. Throughout the year, Clifton Gunderson also revises settlements for a variety of reasons such as field audit application, appeal results application, requests to reopen cost reports, and correction requests.

Table 3: Number of Settlements Performed in CY 2004	Initial Settlement		Revised Settlement	
	#	Hours	#	Hours
Medicare and Medicaid Nursing Facility	220	55	260	20
Medicaid Only Nursing Facility	20	40	20	20
Medicaid and Medicare Hospital Facility	85	20	155	10
Medicaid and Medicare Hospital with NF	23	40	36	20
Outpatient Rehabilitation Agency	130	30	15	10
Federally Qualified Health Center Rural Health	80	30	80	10
Intermediate Care Facility for Mental Retardation	25	30	10	10
State DMHMRSAS Facilities	13	20		

Providers have different fiscal year ends and therefore Clifton Gunderson settles cost reports continuously throughout the year. According to regulation and contract, it must complete the initial desk audit within 180 days of receipt of a complete cost report. Since almost two-thirds of the providers have fiscal year-ends of 12/31, the settlement deadlines for most providers cluster in November (See Table 4.)

Table 4: Demographics of Nursing Facility Cost Report

Fiscal Year Ends in CY 2004	Count of NF Provider Fiscal Year Ends	Percent of the Total Count per Month	Submission Deadline	Month/Year Settlement Due
January	5	2%	June 2004	December 2004
February	6	2%	July 2004	January 2005
March	7	3%	August 2004	February 2005
April	1	0%	September 2004	March 2005
May	8	3%	October 2004	April 2005
June	19	7%	November 2004	May 2005
July	5	2%	December 2004	June 2005
August	11	4%	January 2005	July 2005
September	29	11%	February 2005	August 2005
October	3	1%	March 2005	September 2005
November	2	1%	April 2005	October 2005
December	168	64%	May 2005	November 2005
	264	Total Count		

Clifton Gunderson, however, organizes the work to smooth out the workload and complete the audits timely. Table 5 shows the distributions of both initial and revised settlements for nursing facilities and all other providers by month. Table 5 also includes individual counts by months for all provider types.

Table 5: Number of Settlements Completed in 2005 by Month

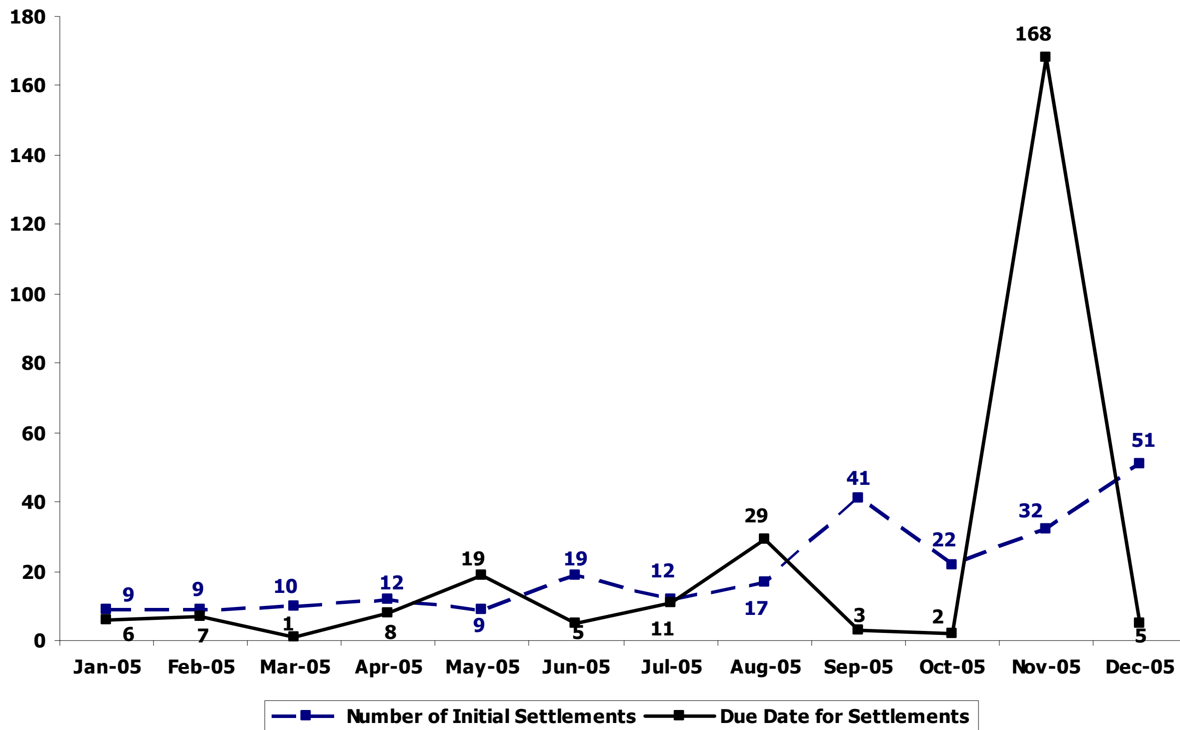
	NURSING FACILITYS				OTHER PROVIDERS			
	Initial Settle-ments	**Revised Settle-ments**	**Total**		**Initial Settle-ments**	**Revised Settle-ments**	**Total**	**Grand Total**
Jan-05	9	19	28		15	5	20	48
Feb-05	9	84	93		23	11	34	127
Mar-05	10	73	83		20	6	26	109
Apr-05	12	18	30		43	4	47	77
May-05	9	12	21		32	16	48	69
Jun-05	19	111	130		17	5	22	152
Jul-05	12	30	42		30	4	34	76
Aug-05	17	75	92		9	16	25	117
Sep-05	41	21	62		11	9	20	82
Oct-05	22	6	28		9	1	10	38
Nov-05	32	18	50		49	15	64	114
Dec-05	51	20	71		16	3	19	90
Total	**243**	**487**	**730**		**274**	**95**	**369**	**1,099**

As demonstrated in Table 5, sixty-six percent of the total settlements nursing facilities receive are revised settlements. Only twenty-five percent of total settlements for other provider types are revised settlements.

The number of revised settlements for nursing facilities is high compared to other types of providers because the majority of events that can trigger a revision, field audits and appeals, involve nursing facilities. Field audits for nursing facilities represent at least 90% of the total audits across all provider types. Nursing facilities represent 95% or more of the appeals conducted by Clifton Gunderson. Since nursing facilities are on a prospective reimbursement system, a revision to one year automatically requires a revision to the subsequent year. This means that one appeal or field audit being applied can impact two or more periods.

Clifton Gunderson smooths out the workload in two ways. First, it attempts to complete desk audits of some cost reports earlier than the deadline. Second, it shifts staff from field audits to desk audits during the peak cost report desk audit months. Figure 2 illustrates how Clifton Gunderson smooths out settlements relative to the actual deadlines for nursing facility settlements.

Figure 2: Illustration of Nursing Facility Initial Settlements Compared to Due Dates by Month



2.3 DMAS Reports Used in Cost Reporting

Table 6 provides a generalized overview of key activities and dates for desk audit for the nursing facilities, DMAS, and Clifton Gunderson from a December 31 year-end provider's perspective, and Table 7 summarize these activities and dates for providers with selected fiscal year-ends.

DMAS is responsible for producing two reports that directly impact rates. One is used by nursing facilities to prepare the cost report. The MMR-240 report is produced two months after the end of the fiscal year and summarizes Medicaid charges, days, and payments from approved claims for dates of service during the fiscal year. This report is necessary for completion of the cost report. The second report, the CMI report, is produced two months after the fiscal year-end and refers to an acuity-based index used to neutralize and case mix adjust direct costs for rate setting. Providers do not need the CMI reports to file the cost report but most find it very useful for anticipating their revenue in the coming year.

Table 6: Key Functions from Provider Fiscal Year-End to Final Cost Settlement

Month	% of Cost Reports Settled (Free-Standing n=243)	Nursing Facility with 12/31 FYE	DMAS	Cost Settlement
December	21%	FYE For Provider		
January	4%	Provider Submits All Claims For FYE		
February	4%		Final CMI Neutralization Scores And Case Mix Adjustment For 1st Semi-Annual Rate Completed (2/15)	
March	4%	Provider Completes Audited Financial Statements	MMR Reports For 12/31 FYE Providers Are Generated And Sent To Providers (March 5)	
April	5%			
May	4%	Cost Reports Are Due For Cost Settlement 5/31		
June	8%			• Completeness Audit • A Letter Is Sent For Providers Not Meeting The 150-Day Deadline
July	5%			Cost Settlement Begins For Providers With Completed Cost Report Packages
August	7%		Final Case Mix Adjustment For 2nd Semi-Annual Rate Completed (8/15)	Some Cost Settlements Completed
September	17%			More Cost Settlements Completed
October	9%			Many Cost Settlements Completed
November	13%			Cost Settlements And NPRs Are Completed For All Remaining 12/31 FYEs Received Timely

Table 7: Cost Report Data Item Sources and Due Dates

Cost Report Fiscal Year-end by Quarter Ending	Final CMI Scores and Case-Mix Adjustment for 1st Semi-Annual Rate Completed	MMR Reports of Charges and Payments are available to Nursing Facilities	Nursing Facility completes Audited Financial Statements (Industry Standard)	Cost Report is due to DMAS	Final Case Mix Adjustment for 2nd Semi-Annual Rate Completed	Cost Report Settlement Due
3/31/2004	5/15/2004	6/05/2004	5/31/2004	8/31/2004	11/15/2004	2/28/2005
6/30/2004	8/15/2004	9/05/2004	3/31/2004	11/30/2004	2/15/2005	5/31/2005
9/30/2004	11/15/2004	12/05/2004	11/30/2004	2/28/2005	5/15/2005	8/31/2005
12/31/2004	2/15/2005	03/05/2005	2/28/2005	5/31/2005	8/15/2005	11/30/2005

3. Improving the Availability of Reports Used in Cost Reporting

DMAS currently furnishes data that is not provider specific on its web page. Non-provider specific data includes inflation, FRV factors, and ceilings. Provider specific data on the MMR and CMI reports are produced electronically—then printed and mailed to providers by Clifton Gunderson.

Providers have expressed concerns with the current process for distributing provider specific data. While the data is usually mailed timely, it sometimes does not get to the person or persons who use it most. It may be mailed to the CFO when it needs to go another staff person. It may be mailed to a home office even though each facility also needs to have this information. It also takes time and effort on the part of the Clifton Gunderson to mail initially and to respond to requests for replacement or duplicate copies. The workgroup reviewed options developed by DMAS to respond to these concerns.

3.1. Options

3.1.1 Posting Reports on the Web

Industry representatives recommended that DMAS post provider specific reports on the web so that provider staff could view them or download them as needed. Several years of reports could be maintained on the web site. DMAS could set up a site with password access for the provider. Security would not have to be at the highest level, since the information would not include protected health information.

3.1.2 E-mailing Reports and Web Posting Notification

DMAS information management staff also identified an alternative dissemination strategy. The reports of interest are produced only once or twice a year. While they are usually produced on a schedule, sometimes the reports are delayed. Since the reports are infrequent and occasionally delayed, the provider may not know when the reports have been posted unless DMAS or Clifton Gunderson notifies the provider. When notifying the provider, it may be just as efficient to e-mail reports in a secure file when they are produced. DMAS could also combine an email modification with the posting of reports on the web. Maintaining email addresses could be an issue, but the provider could be responsible to maintain its email addresses.

3.1.3 Pre-populating Cost Reports with Data from Other Reports

A third strategy is to pre-populate the electronic cost reports with facility specific data furnished by DMAS. This could be implemented as an alternative to, or in conjunction with, either posting or e-mailing the reports. Clifton Gunderson audits cost reports using a DMAS Oracle database. When Clifton Gunderson's staff "set up" a cost report for a specific provider fiscal year on the Oracle database, the cost report is currently pre-populated with ceilings, inflation, and CMI scores. DMAS is studying how it can add the MMR data to this process. Providers, however, do not have access to the Oracle database used by DMAS and Clifton Gunderson or a similar process. Depending on the strategies chosen for improving the cost report submission process, it may be possible to pre-populate cost reports for providers with the latest information available.

3.2. Conclusion

At the time of this report, the workgroup believes it is premature to make a final decision whether to post facility specific data for cost reporting on the web for retrieval by each facility, or to e-mail the data directly to each nursing facility, or to implement both. The workgroup will continue to meet and believes it will be in a position to make a decision by the end of 2006. The workgroup believes it will be feasible to implement the selected option by July 2007, but it is contingent on implementation of the National Provider Identification program, a major information technology issue that must be completed by May 2007. This will result in relatively small gains in efficiency at both nursing facilities and Clifton Gunderson.

DMAS will continue to develop, and the workgroup will continue to consider, the option of pre-populating cost reports as an alternative or an additional way to convey the necessary information to nursing facilities in an efficient manner.

4. Improving the Cost Report Submission Process

The workgroup identified several areas in which to improve cost report submission by using electronic cost reporting. The following criteria for evaluating the options were agreed upon the by the workgroup.

- **Provide the opportunity to make the data more accurate**: Standardization and accuracy in data collection is an important consideration when improving the current cost reporting system. The ability to identify questionable data entries in advance is one functionality the workgroup would like incorporated in an improved cost reporting system.

- **Provide a single simple data-capturing tool that does not add significant additional collection time**: Electronic data collection is nothing new to the health industry. There are many techniques available that allow the ability to download information from Medicare reports, financial statements, and a facility's accounting system directly into spreadsheets. This ability reduces the need for duplicating data available in one application that is again used in another application. The workgroup would like a tool developed to improve the cost reports that is easy to use, maximizes import and export technologies, and adds little to no additional time to complete.

- **Be scaleable to suit the financial and technical capacity of different nursing facilities**: The cost reports system design should be scaleable. The intent is that an improved design will achieve some advance in standardization, ease-of-use, and accuracy without disrupting the various systems in current use. The providers are willing to invest in their own systems to upload cost report data to DMAS. Providers should also be permitted to continue providing cost report data in the current manner if they choose. The workgroup agreed to allow for continued modifications and enhancement over time when the opportunities for improvements exist.

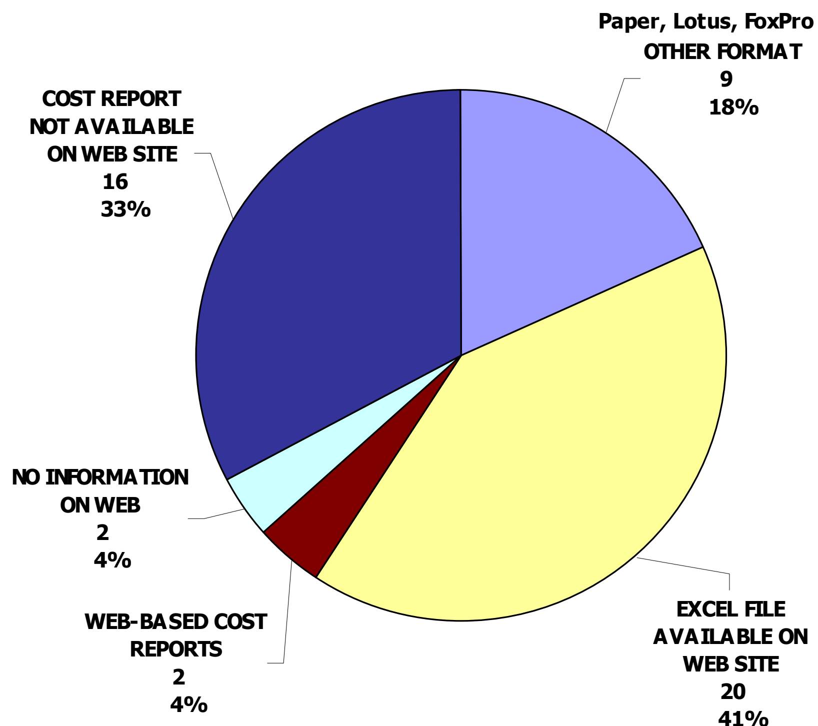
- **Capture data that can be used to more efficiently manage resources**: An important area the workgroup would like to explore is options to improve management and audit functions. Data elements currently not captured in the Oracle database, such as data reported in the Medicare report, should be considered an opportunity that can be built into an improved cost reporting application. This enhancement could allow managers to better analyze historical data and improve variance analysis.

4.1. Survey of Other States

To determine the variety of Medicaid cost reporting processes, DMAS conducted a survey of all fifty states' Medicaid web-sites. Information was collected on forty-eight states. DMAS accessed each state's Medicaid web-site and searched for references about the type of cost report used and whether providers have the ability to download the state version of the cost report from a web page. When available, a state's cost report was downloaded for evaluation. If a state did not post its cost report on the web, then DMAS contacted a state representative working in the provider reimbursement unit for more information about their cost report design[1].

Cost reports can generally be described as paper, electronic, or web-based. The majority of states use Excel versions of cost reports. Twenty states have their Excel cost reports available on line. Sixteen states use Excel versions of cost reports but do not post them on their Medicaid web site. Nine states use and collect paper cost reports or a software product such as Lotus or Fox Pro. Massachusetts and Texas have developed web-based cost reports.

Figure 3: Results from Cost Report Survey



[1] This survey did not include information from California and Alaska.

Differences in sophistication exist among the twenty Excel versions of cost reports. One state uses 32 different workbooks to collect cost report data. Each workbook is sent individually to their provider reimbursement division for processing. Most states, including Virginia, have developed an Excel form with multiple worksheets for each of the various schedules needed for cost settlement.

Several states have highly developed custom Excel applications incorporating Visual Basics (VB) programming. Programming in VB is a combination of visually arranging components or controls on a form, specifying attributes and actions of those components, and writing additional lines of code for more functionality.

One of the most highly developed Excel applications identified in the survey was Florida's Agency for Health Care Administration (AHCA) "SEXTANT" application[2]. This application was developed by the Florida Medicaid's information technology staff with input from nursing facility providers, to provide uniform, streamlined cost reports capable of performing "front-end" data validation before cost report submission.

Florida's legislature called for the implementation of electronic submissions of cost reports for approximately 650 nursing facilities participating with Florida's Medicaid program. When data is entered on the input worksheet, the appropriate schedule changes can be reviewed by clicking on the schedule tab. One feature built into the SEXTANT application that interested members of the workgroup was the ability to validate data entry items and the ability to locate possible data entry errors. Many schedules in SEXTANT have built-in validity checks. In some instances, an error message may appear on the applicable schedule to the right side of the row being checked.

In other circumstances, validation checks are a part of the applicable schedule. When data input is completed for the entire cost report, a completed cost report validation feature has been built in the SEXTANT application. The "VALIDATE" tab in the cost report contains logic that identifies any remaining exceptions.

SEXTANT currently checks for more than 190 different potential exceptions to the cost report. For example, SEXTANT will check to ensure that all required data fields contain data; that the selected data on one schedule agrees with the same data on another schedule; that "Not Applicable" schedules do not contain input data; etc.

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[2] http://ahca.myflorida.com/Medicaid/cost_reim/ecr.shtml

4.2 The VHI Model

Early in the workgroup's discussions, interest was expressed in exploring the feasibility of using a web-based cost report. VHCA and several providers suggested DMAS representatives meet with staff at Virginia Health Information (VHI) and examine their web-based data entry tool EPICS (Efficiency and Productivity Rankings to Improve Healthcare) information collection system[3]. This tool is used by nursing facilities to report financial and utilization data.

On April 12, 2006, DMAS representatives met with Michael Lundberg, Executive Director of VHI, and Richard Walker, a consultant for VHI, to review the EPICS tool.

VHI works with private organizations and public bodies that use health data. VHI collects information and data on Virginia hospitals, health insurers, nursing facilities, physicians, retirement centers, and other health care providers in a web-based environment. VHI is working with groups to cost-effectively use health data and disseminates the information through consumer publications, HMO financial and utilization reports, health industry reports, long term care reports, and patient level detailed reports.

Data collection through EPICS is performed through a sequence of input masks (tabs for specific financial schedules and health utilization information), the initial system validation of the data, the generation of data status through error messages, and the storage and preprocessing of data before it is loaded into a Microsoft Access database. Reports can be produced that are health provider specific and rank facilities within their geographic region on costs, charges, productivity/utilization, and financial viability. VHI noted the advantages of using a web-based tool.

Ease of Use: Web-based data entry enables facility staff to logon to a secure website to access data entry web pages to input various financial and operational data.

Speed: Web-based data entry is fast and removes the need to mail spreadsheet and many "paper" schedules.

Preview: Before submitting data for processing, facility staff can view detailed calculations, including current and prior year data entry amounts. This feature allows for higher-quality data entry due to edit and logic checks performed at the time of data entry. In addition, if an entry varies more than twenty-five percent from last year's entry, the data entry portal is highlighted in yellow signaling a need for additional verification.

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[3] http://www.vhi.org/about_staff.asp

Reports Delivery: Once the analysis of the submitted data is completed, the submitting health care entity has 30 days to comment on the resulting report information before it is published for public viewing. The system also has user-defined query management features that allow for individualized reporting beyond the standard "canned" reports provided to the general public.

Efficiency: EPICS requires no software installation and is easily updated in a single web-based environment. Transcription errors are reduced due to built in logic and error editors. Help comments or data element definitions, for example, can be built in. An e-mail notification feature is also built into EPICS.

Standardization: Having an accepted database standard and data entry form allows for the collation of data from various provider types (single level and multiple level nursing facility) in a centralized web-based application. The more data collected, the better the ability to analyze it, identify trends, and make concrete recommendations for program improvement.

Several issues of interest to DMAS representatives were discussed. These issues include:

1. Document Submission: The flexibility of document submission from facilities to VHI (e-mailed PDF files, mailed paper copies, Microsoft Word and Excel documents, etc.) was of interest to DMAS representatives. VHI is very flexible in allowing different document types to be submitted as support documentation.
2. Passwords and Security: A single password for accessing the system is provided in a letter sent prior to a facility's fiscal year-end. This single password may be distributed among facility employees and is used for both data entry and final data submission. There is a concern by DMAS technical experts concerning password standards enforcement. (i.e. password must be eight characters, etc).
3. Report Flexibility: Report flexibility includes the ability to copy and paste from any web report into Excel or Access for further analysis by the provider.
4. Pre-populated Fields: While VHI does not currently use data not entered directly through EPICS to populate their Access database, they indicated that this would not be a problem to build into their existing system. An example DMAS might be interested in is the ability to pre-populate MMR report information.

5. Data entry: Currently, nursing facilities must input the data step by step into EPICs but an upload feature could be added to remove data entry. Nursing facilities indicated that they wanted to be able to upload information if DMAS were to pursue a web-based cost report.

VHI indicated that the timeframe needed to design this web system was approximately two months and required an outside contractor. The site and the database servers are being hosted by a private Internet Service Provider.

4.3 Options

Various electronic cost reporting options were examined by the workgroup. The options presented are based primarily on the workgroup's vision and goals and describe a recommended business operations model that provides for efficient and effective data management for the nursing facility providers and DMAS. Outlined below are three options including identified pros and cons that were gathered from discussions between industry representatives and DMAS staff.

4.3.1 Option 1 - Enhanced PIRS 1090 Excel Spreadsheet

This option would add a data input worksheet in the current cost report that can populate the various individual schedules in the PIRS Cost Report (See Figure 4). Providers could map the data in their systems to the standard input sheet. If provided in a standard format, DMAS can upload directly to its Oracle database after review. This option can be expanded to include Medicare cost reporting data elements currently not captured in the Medicaid cost report for multi-level facilities (PIRS 1090 short form). An alternative is for DMAS to download relevant data elements from the Medicare electronic cost report file already submitted to Clifton Gunderson.

Pros

- ***Minimal input actions*:** Facilities could map data elements from internal systems to the input sheet eliminating the need for duplicate data entry.
- ***No redundant data entry*:** DMAS would output the data from the input sheet into the Oracle Cost Report after review.
- ***Efficiency**:* More efficient and possibly more accurate.
- ***Rapid development*:** Requires the least amount of development time.
- ***Flexible*:** Providers that choose not to map to the input sheet can still continue to manually enter data.

- ***Consistency*:** The individual schedules are not altered from the current Excel design.
- ***Cost Consideration*:** Least expense to implement for DMAS and the provider community.

Cons

- ***Minimal Process Change*:** Minimal attempt to upgrade the current cost reporting system.
- ***Limited Efficiency Gain*:** DMAS (Clifton Gunderson) would save approximately 30 minutes of time per cost report.
- ***Limited Data Integration*:** Does not integrate data elements from other sources (MMR-240 and Case-Mix Index) into the design.
- ***No Benchmarking*:** Does not integrate comparisons or benchmark data.
- ***No Validation*:** Does not provide for built-in validation.

4.3.2 Option 2 - Enhanced PIRS 1090 Excel Spreadsheet with Embedded Visual Basics for Applications (VBA)

This option would expand the functionality described in Option 1 to include various data validation checks through the use of VBA. Option 2 incorporates both formula-based and macro-based processes. Formula-based processes include logical checks for data consistency and completeness and are presented in a validation worksheet. Macro-based processes include logic that can be incorporated in any of the worksheet schedules and can issue warning messages if certain logical conditions are not met. Macro-based processes can also be written to describe detected exception conditions that need some action from the user.

Figure 4: Modified PIRS 1090

COST REPORTING FORMS FOR NURSING FACILITY

NURSING FACILITY WITH MULTIPLE LEVEL OF CARE OR HOSPITAL-BASED NURSING FACILITIES

EFFECTIVE JULY 1, 2002

FOR COST REPORTING PERIODS ENDING ON AND AFTER JULY 31, 2002, THE FOLLOWING COST REPORTING FORMS ARE TO BE USED TO FACILITATE MEDICAID SETTLEMENT.

NO SUBSTITUTES MAY BE USED UNLESS AUTHORIZED BY THE DIVISION OF COST SETTLEMENT AND AUDIT IN WRITING. THE PIRS FORMS WILL CONSIDER ALL ADJUSTMENTS

NECESSARY TO INCORPORATE THE PROSPECTIVE REIMBURSEMENT RATE FOR THE NFs FIRST SEMI-ANNUAL PERIOD.

COST REPORTING FORMS (PIRS 1090 SERIES)

INPUT SHEET	**THIS WORKSHEET IS USED TO DOWNLOAD COMPLETE COST REPORT DATA INTO THE COST REPORT**
SCHEDULE A-1	CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER
SCHEDULE A-3	COMPUTATION OF PATIENT INTENSITY REIMBURSEMENT SYSTEM BASE OPERATING COSTS
SCHEDULE A-4	COMPUTATION OF DIRECT PATIENT CARE NURSING SERVICE COSTS
SCHEDULE C	COMPUTATION OF TITLE XIX DIRECT PATIENT CARE ANCILLARY SERVICE COSTS
SCHEDULE D	STATEMENT OF COST OF SERVICES FROM RELATED ORGANIZATIONS
SCHEDULE E	STATEMENT OF COMPENSATION OF OWNERS
SCHEDULE F	STATEMENT OF COMPENSATION OF ADMINISTRATORS AND/OR ASSISTANT ADMINISTRATORS
SCHEDULE J	CALCULATION OF MEDICAL SERVICE REIMBURSEMENT SETTLEMENT
SCHEDULE J, PART II	COMPUTATION OF NURSING FACILITY MEDICAL SERVICE POTENTIAL PROSPECTIVE REIMBURSEMENT
SCHEDULE J, PART III	SETTLEMENT COMPUTATIONS
SCHEDULE J, PART IV	ANALYSIS OF NURSING FACILITY INTERIM PAYMENTS FOR TITLE XIX SERVICES
SCHEDULE J, PART V	ANALYSIS OF QUARTERLY TITLE XIX PATIENT DAYS
SCHEDULE J, PART VI	ACCUMULATION OF TITLE XIX CHARGES
SCHEDULE J-1	CALCULATION OF NATCEPs REIMBURSEMENT SETTLEMENT
SCHEDULE J-2	CALCULATION OF CRIMINAL RECORD CHECK COSTS REIMBURSEMENT
SCHEDULE K	DEBT AND INTEREST EXPENSE
SCHEDULE L	LIMITATION ON FEDERAL PARTICIPATION FOR CAPITAL EXPENDITURES QUESTIONNAIRE
SCHEDULE N	NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM COSTS AND COMPETENCY EVALUATION PROGRAMS (NATCEPs)
SCHEDULE R	COMPUTATION OF FAIR RENTAL VALUE
SCHEDULE R-1	SCHEDULE OF ASSETS, RECONCILIATION SCHEDULE, AND INSTRUCTIONS
SCHEDULE S	DISCONTINUED
SCHEDULE S-1	COMPILATION OF NURSING SALARIES, BENEFITS, AND HOURS

THESE FORMS MUST BE FILED WITH THE COMPLETED MEDICARE COST REPORTS CMS 2540 OR CMS 2552 PACKAGE INCLUDING ALL WORKSHEETS AND SUPPLEMENTAL SCHEDULES AS REQUIRED BY MEDICARE.

In addition, a certification worksheet can be added incorporating electronic signature capability. A Notes worksheet can be added for explanations of any valid variances noted in the verification worksheet that are not "fatal" errors. Visual basics coding can be incorporated that allow for Internet submission in a compatible file structure for upload into the existing Oracle database. This option can be expanded to include Medicare cost reporting data elements currently not captured in the PIRS 1090 short form or to download relevant data elements from the Medicare cost report file already submitted to Clifton Gunderson.

Pros

- ***Minimal input actions***: Making a choice by selection from a menu, or from radio buttons, rather than by typing in a lengthy string of characters that reduces the possibility of typographic errors.
- ***No redundant data entry***: Removes redundant data entry, currently perceived as a waste of effort.

- ***Compatibility of data entry with data display*:** The format of data entry information can be designed to closely replicate the format of currently displayed Excel schedules.
- ***Informative feedback*:** A built-in response by the system for user actions or alerts can be designed in the application.
- ***Error Prevention and simple error handling*:** The system could detect many errors made by users and offer simple, constructive, and specific instructions to correct a possible error.
- ***Easy reversal of actions*:** As much as possible, actions can be built that are reversible. The unit of reversibility may be a single data entry or the complete transaction. Validation throughout the application can be made mandatory before a cost report can be saved and submitted.
- ***Customizing applications*:** Custom toolbars and menus that automate common tasks can be built into the application.

Cons

- ***External Development*:** This option may require external resources to implement.
- ***Cost:*** This option may be more costly.
- ***Lengthy Implementation*:** This option offers a complex and robust solution for many of the issues identified by the workgroup and may therefore require substantial development time.
- ***Limited Data Integration*:** May be difficult to integrate data elements from other sources (MMR-270 and Case-Mix Index) into the design.
- ***Software Standardization*:** May require all facilities to use the same version of Microsoft Office.

4.3.3 Option 3 - Interactive Web-Based Application

This option would recreate the cost report format as a web form. The delivery system for Option 3 changes from an Excel cost report to a web-based version. This option would recreate each of the schedules in the current PIRS 1090 form in a web-based data entry format. Instead of typing in data on an Excel spreadsheet, the form has multiple "tabs" representing the current cost report schedules. The web-based tool can also be designed for providers to upload into the Input worksheet described in Options 1 and 2. MMR, CMI, ceiling, inflation and other source items from DMAS can be pre-populated. Prior year comparisons and/or benchmarks can be included.

Pros

- ***Ease of Use***: Web-based data entry enables facility staff to logon to a secure website to access data entry web pages. Does not require providers to have specific standardized software.
- ***Speed***: Web-based data entry is fast and removes the need to mail spreadsheet and many "paper" schedules.
- ***Data Validation***: Before submitting data for processing, facility staff can view detailed calculations, including current and prior year data entry amounts. This feature allows for higher-quality data entry due to edit and logic checks performed at the time of data entry.
- ***Efficiency***: This option requires no software installation for the providers and is easily updated in a single web-based environment. Printable data element definitions can be built in through a mouse-over feature. An e-mail notification feature can be built into the application.
- ***Standardization***: Having an accepted database standard and data entry form allows for the collation of data from various provider types (single level and multiple level nursing facility) in a centralized web-based application. The more data collected, the better the ability to analyze it, identify trends, and make concrete recommendations for program improvement.

Cons

- ***Cost***: This option may be the most costly and may require an outside vendor resulting in costs to DMAS.
- ***Lengthy Implementation***: This option offers a complex and robust solution for many of the issues identified by the workgroup and therefore may require substantial development time. This option can be implemented in stages, however.

4.4 Conclusion

These three options are not necessarily competing alternatives, but may be seen as stages of improvement. Option 1 is the easiest to implement, but has only modest benefits. The workgroup agreed it should be implemented as soon as possible. DMAS anticipates having it operational by the end of 2006. Option 2 involves more cost and time to implement, and Option 3 more yet. They also would bring greater gains in efficiency. The workgroup will continue to work on these and provide input to DMAS with the goal to implement additional improvements by the end of 2007.

5. Improving the Management of Documents

Nearly every organization faces the same dilemma: what to do with all the paper and electronic documents stored throughout the organization. As the volume of both hard copy and electronic information increases, the importance of effectively managing the information has become critical. When the workgroup considered these common issues surrounding an organization's manual storage process, it became evident that an electronic document imaging solution could be of value when considering options to improve efficiencies in the cost report process. Some of the benefits for DMAS and the nursing facility community are addressed below:

- **Multiple copies of the documents are not necessary.**
  Because document imaging technologies enable organizations to store exact copies of the original document, users are able to access this information in a secure and reliable fashion whenever needed and annotate without modifying the original document. The information can be shared with other users concurrently.

- **Official copies of the document can be easily identified.**
  Organizations are able to develop standardized procedures associated with how the hard-copy documents are handled, scanned, indexed, and managed. Organizations are able to utilize the electronic version of the document in lieu of the original document, if the original is no longer available.

- **Legal discovery issues and costs are greatly reduced.**
  Organizations are able to follow records retention policies and procedures, as well as to quickly identify relevant documents associated with legal discovery requests or other information requests by government regulators. Without these technologies, organizations are forced to identify all copies of the requested document/information, collate and review these documents, rather than simply identifying and reviewing the information managed by the system.

- **Full disaster recovery capabilities are enabled and users have the ability to quickly locate documents.**
  As noted in the items above, it is fairly straightforward for users to select those documents that need to be retrieved, processed, or viewed. It can take a considerable amount of time on a daily basis to not only locate documents throughout an organization, an off-site storage area, and to establish a manual tracking system.

- **The number of missing documents is reduced.**
Using document imaging technologies enable organizations to save documents. An important aspect of saving documents electronically is related to security and non-alterability.

- **Time and cost in storage is reduced.**
Using document imaging technologies enable organizations to achieve savings through the elimination or reduction of the cost associated with offsite storage facilities.

- **Enhance Document Dissemination.**
DMAS could distribute settlements and other reports electronically.

5.1. Options

5.1.1 Paperless Cost Report Storage

Utilizing a process or application that allows for the electronic submission of cost report data in a specific, predefined format into a centralized database repository as described in section 4 is the first step in a paperless office. The next step is to review, analyze, and compare submitted cost report data electronically and then store the "file" electronically. Under the current process, there is a paper file two inches thick on average for each completed desk audit.

The electronic cost report, other information, and documentation submitted by nursing facilities to support their cost report submission and all the workpapers and other information prepared by Clifton Gunderson and DMAS could be maintained in an electronic "binder" using a centrally managed document management system. The binders could be set up to reflect specific fiscal years thus allowing for DMAS' document retention policies to be more easily followed and enforced. A potential savings could be the elimination or reduction of the cost associated with offsite storage facilities. In addition, traditional paper-based reports would no longer need to be printed thereby reducing the costs associated with printing.

Retaining all relevant information related to a nursing facility's cost report in a centralized location would have efficiencies not previously available due to the manual processes currently being utilized. A searchable and index-able electronic filing system has advantages over

the paper filing utilized today. In addition to efficiencies, other benefits would be derived from acquiring and implementing this type of system. Information could be shared based on security privileges among a specific nursing facility, DMAS, and Clifton Gunderson. Workpapers could be secured to reduce the chances of unauthorized modification of finalized documents. Access to this information would be instantaneous.

Security could be set where only specific individuals from a specific provider would have access to the binders related to their entity. The security could be set so as to allow these individuals access to upload documents to their binder. In addition, it could be set to allow these individuals access to view all or part of the information contained in their assigned binder. Security should be flexible and granular enough to cover most situations.

Several key prerequisites to acquiring and implementing this type of system are making sure that:

1. The system chosen fulfills the needs and objectives of DMAS and Clifton Gunderson,
2. The system chosen has sufficient security controls to set security privileges on binders and documents within binders,
3. The system has the ability to set and enforce document retention policies, and
4. The system is hosted in a secure and centralized location that is accessible by the Providers, DMAS, and Clifton Gunderson.

Clifton Gunderson has begun research on document management systems. Clifton Gunderson is currently testing and will probably be deploying over the next 18 months an application called GoFileRoom from Immediatech Corporation (*http://www.immediatech.com/products/goFileRoom_overview.htm*). Clifton Gunderson is currently testing this system using Immediatech's hosted model.

5.1.2 Remote Access to Cost Report Documentation

Using a centralized database repository would mean that data could be instantaneously retrieved. This would also allow DMAS and Clifton Gunderson to share the cost report information. If DMAS needs to see the cost report, Clifton Gunderson must retrieve a paper file and deliver it to DMAS. Eventually, field auditors also may have access to the

electronic binder while on site during a field audit rather than having to wait to get back to the office to review previously submitted documents.

5.1.3 Submitting Attachments Electronically

Providers could continue to submit documents or files on a disk and Clifton Gunderson could scan them or load them into the electronic binder. It would be preferable for providers to simply e-mail PDF, Microsoft Word or Excel documents of their trial balances, financial statements, supporting workpapers, and other information. A system could be acquired to attach documents to the electronic cost report or upload attachments to the electronic binder that would be prepared specifically for each cost report. If submission of supporting documentation was part of the validation process before filing the electronic cost report, this would accomplish a major part of the completeness audit automatically. If additional documentation is required, the provider could also submit it by e-mail rather than in paper as currently required.

5.1.4 Electronic Notifications

During the course of a year, DMAS and Clifton Gunderson send numerous letters to providers, generally to a central contact person. Much of the information transmitted begins in an electronic format and is printed out and mailed to Providers. The types of letters currently sent to nursing facilities include: Fiscal year-end letters containing cost report due dates, location of cost report templates on the DMAS website and the nursing facility's specific days, payments and charges data from the DMAS information system; cost report settlements; Interim Rate letters; Notices of Program Reimbursement sent to Providers after settlement of their cost report. It may be possible to either e-mail the information directly to nursing facilities or to post the provider specific data to a secure location of the DMAS website and simply e-mail a notice to a nursing facility that the information is available.

5.2. Conclusion

The workgroup will continue to research document management systems and will recommend a strategy by July 2007. There may be some additional up-front costs, but there will also be savings of storage and retrieval costs and printing costs.

6. Reduce Look-Back by One Year

6.1. Background

Payments to nursing facilities are made on a per diem basis. Per diem payments are set using a complex methodology based upon facility-specific Medicaid-allowable costs for serving Medicaid recipients. However, there is a maximum amount that can be paid for direct costs (primarily nursing) and for indirect costs (non-nursing operating costs). These maximum amounts are referred to as "ceilings" and are the result of updates through a process called "rebasing".

The ceilings are established by regulation as a percent of the day-weighted median cost per day by peer group of free standing nursing facilities. Regulations on the nursing facility reimbursement methodology and ceilings for direct and indirect care costs can be found in Appendix 6.

The Medicaid payment methodology for nursing facilities that was in place between 1990 and 2000 utilized direct care and indirect cost ceilings that were not subject to periodic rebasing. The ceilings were simply adjusted annually for inflation. A Joint Legislative Audit and Review Commission (JLARC) study released in January 2000 found that for periods between 1994 and 1999, over 60% of all providers were incurring costs in excess of the direct care ceiling and recommended that rebasing be done every two years. This recommendation was adopted and beginning July 1, 2000, ceilings have been rebased every two years.

The Budget approved by the 2000 General Assembly mandated the biannual rebasing of both the direct care and indirect care ceilings, among other changes. Rebasing requires setting new ceilings using cost data from a more recent "base year". The "look-back" refers to the time period between the base year and the rate year, or the first year to which the rebasing applies. A three year "look-back" means that the base year is three years older than the first rate year. A two year look-back would mean that the base year is two years older than the first rate year.

There have been four rebasings. Base years and rate years, including the rebasing effective 7/1/2006, are below:

Base Year	Year Rebasing Effective	Look-back
CY 1998	FY 2001	$2^{1/2}$
CY 2000	FY 2003	$2^{1/2}$
CY 2001	FY 2005	$3^{1/2}$
CY 2003	FY 2007	$3^{1/2}$

For rebasings effective for FY 2001 and FY 2003, significant efforts were needed to use a $2^{1/2}$ year look-back period. The change from a $2^{1/2}$ year look-back to a $3^{1/2}$ year look-back resulted primarily from regulations adopted in 2002. In 2002, state regulations were codified that included a definition of the base year to be used in the rebasing calculation. The regulations contained the following language:

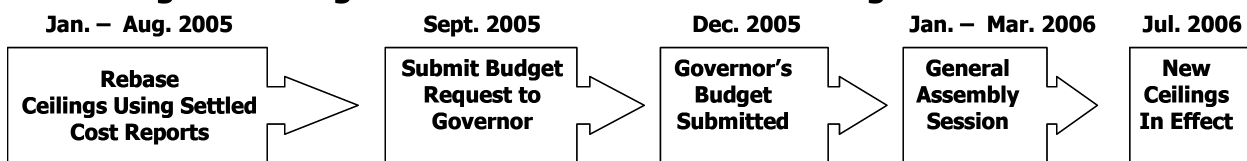
"Base year" means the calendar year for which the most recent reliable nursing facility cost settled cost reports are available in the DMAS database as of September 1 of the year prior to the year in which the rebased rates will be used."

In order to ensure that its budget request accurately reflects nursing facility expenditures, DMAS must complete rebasing by September 1 and estimate its fiscal impact. While the DMAS budget forecast includes inflation for nursing facility reimbursement, it does not include an increase in costs due to rebasing the ceilings to a more current year, unless the rebasing calculation is completed first. The budget development process requires DMAS to submit its proposed budget for the following fiscal year to the Department of Planning and Budget, including any adjustments to the forecast, by September 15.[4]

Since almost two-thirds of the nursing facilities have fiscal years ending in December, and since the December FYE cost reports are the last ones of the calendar year, the base year is made up of the cost reports for the calendar year in which the December cost reports are settled by September 1 of the year prior to the year in which the rebased rates will be used. To use the most recent rebasing as an example, September 1, 2005 was the deadline for cost reports to be settled to be used in the rebasing effective July 1, 2006. The cost reports for providers with fiscal year-end of December 31, 2004 were not settled until November 2005, three months after the deadline. Many of them were actually settled in December since complete cost reports were not submitted by the May 31 deadline. As a result, DMAS could not use cost reports from calendar year 2004 for rebasing. Instead, DMAS used cost reports from calendar year 2003.

[4] While the date for agencies to submit their budgets varies from year to year, it is typically around September 15.

Figure 5: Diagram of Cost Settlement and Budget Process



While the first two rebasings used a $2^{1/2}$ year look-back period, DMAS would find it difficult to use a $2^{1/2}$ year look-back on a regular basis without changes to the current time frames.

6.2. Rebasing for FY2007

During the summer and fall of 2005, representatives from the Department of Medical Assistance Services met with industry representatives concerning the FY 2007 rebasing. The $3^{1/2}$ year look-back was of particular concern to the industry because rebasing using 2003 costs resulted in a $6.1 million (total funds) reduction in projected expenditures for nursing facility services. Rebasing usually results in an increase in the budget because costs per day usually increase. The reduction was probably due in part to industry efforts to contain indirect care costs in response to reimbursement reductions required by the 2002 and 2003 Appropriation Acts that reduced inflation adjustments for indirect care costs and affected costs in the 2003 base year.

At the industry's request, DMAS modeled rebasing using 2004 (as-filed data), which resulted in a $3.4 million net increase over the no rebasing alternative ($9.5 million over the rebasing with a 2003 base year).

During these meetings, the industry expressed interest in using as-filed cost reports instead of settled cost reports for the rebasing calculation used to develop the DMAS budget request, and then settled data for the final rates. As-filed data are available prior to the budget development process (September), and settled data are available before the actual effective date of the rebased rates (the following July), so it would be possible for DMAS to use as-filed date for budgeting purposes and settled data to set the final rates. The regulations call for use of settled data, so DMAS could not do this on its own authority. This option was considered. One possible objection to this option is that, if settlements result in significant adjustments to reimbursements, the final rates can differ from the budget impact originally calculated, and this can lead to a reimbursement discrepancy between expenditures and the appropriation. Based on past years' data, this discrepancy would likely be small in percent terms – one percent or less and relatively predictable. The introduced budget did not include this proposal. However, the introduced budget included an increase in direct and indirect ceilings that resulted in increased reimbursement for nursing facilities.

6.3. Options for Shortening the Look-Back Period

Several actions are possible that could contribute to shortening the current $3^{1/2}$ year look-back period to a $2^{1/2}$ year look-pack period.

6.3.1. Possible Gains From More Efficient Cost Reporting Process

One of the benefits of modernizing the cost reporting process should be a savings in time. Clifton Gunderson has estimated the potential time to be saved from the recommendations in Sections 3, 4 and 5.

For the actual desk settlement process, savings could be realized if the CMS 2540 and the PIRS 1090 were filed and received electronically. Potential savings per cost report may be possible in the following areas:

- If validation features are included at the time of cost report submission, a time savings of up to 1 ½ hours of staff time per cost report could be achieved.
- If data from an electronic cost report can be uploaded into the Oracle database, up to 30 minutes of staff time per cost report could be achieved.
- If the system generated a comparative analysis of prior year and current year cost report data, a time savings of up to 1 hour of staff time per cost report could be achieved.
- If data from the Medicare cost report is loaded electronically so that analysts would no longer have to manually trace amounts or recompute percentages, a time savings of 1 to 1 ½ hours of staff time per cost report could be achieved.
- If communication between desk analyst and provider was entirely telephonic or electronic resulting in shorter turn-around times for documentation requests, a time savings of up to 1 hour of staff time per cost report could be achieved. This alone could save up to a week in elapsed time by receiving documentation quicker.
- If work papers and notes are linked electronically to the cost report, a time savings for management review of up to 1 ½ hours of staff time per cost report could be achieved. Document review could be performed electronically. Managers would not have to re-calculate work sheets and trace ceilings and other DMAS supplied data.

- If NPR letters and settled cost reports could be communicated electronically, instead of mailed, to nursing facilities, a time savings of up to 30 minutes of staff time per cost report could be achieved.

Clifton Gunderson estimates that it may be possible to realize a savings of up to 15% in desk review time with a properly designed electronic environment. This is based on potential savings of 8 hours or more on a complex desk review budgeted for 50 hours. If savings in elapsed time are comparable, then Clifton Gunderson could save almost a month. However, this is only an estimate and would depend on the options chosen and the implementation schedule.

To reduce the look-back period, to $2^{1/2}$ years would require that cost reports for 12/31 fiscal year-end be completed three months earlier than normal (assuming that they are timely filed). This would be reducing the amount of time for settlement by 50% (assuming no other changes). While Clifton Gunderson has estimated a 15% time savings, the estimate has a high degree of uncertainty at this point in time. Assuming that changes are implemented over the next year and a half, it would be unwise to assume sufficient savings in time for the next (FY 2009) rebasing if it is based solely on time savings from cost reporting efficiencies.

6.3.2. Earlier Filing by Providers

VHCA members have indicated their desire and willingness to explore, develop, and implement technology enhancements that would shorten the time between the end of the facility's fiscal year-end and when DMAS could begin to use the data for analysis and rebasing. (VHCA indicated that their members are willing to bear a significant portion of the cost necessary to implement enhancements related to electronic cost report filing and submission.) In addition, providers are willing to consider shortening the cost report submission period to something less than 150 days to facilitate the use of a $2^{1/2}$ year look-back period.

Work group members have proposed to reduce the submission deadline from 150 days to 120 days (four months) contingent on DMAS agreeing to the following changes:

1. That the process for developing documents, now prepared by either DMAS or Clifton Gunderson and provided to nursing facilities, that are necessary for the full, accurate, and timely completion of the Medicaid cost report will be significantly enhanced so as to insure their availability to meet the new four month submission deadline.

2. That the workgroup examine the report and documents that now constitute a complete cost report submission and identify possible changes that will facilitate the proposed four month preparation and submission schedule without compromising the quality of the information being provided to the department. One specific suggestion is to modify the requirement that audited financial statements must be submitted at the time of cost report filing. VHCA supports the requirement to submit audited financial statements but would like to see the timing for submission separated from that of the cost report.

3. That DMAS modify the requirements for cost settlement to reflect a four month settlement period. Based upon discussions within the workgroup to date, VHCA believes that there exists sufficient opportunity for efficiency improvements and process enhancement to make this new four month settlement period a very realistic and achievable goal.

4. That DMAS and provider representatives to the workgroup work to identify an appropriate phase-in period for the changes addressed above.

DMAS appreciates the willingness of providers to reduce the time to submit a cost report to 120 days. DMAS notes that all providers do not meet the current 150 day deadline, however (please see Figure 1). While the majority of those who do not meet the deadline are delinquent by only a few days, a few days could be significant if the goal is to complete the calendar year desk audits by September 1.

This proposal would still require DMAS to complete cost report desk audits 60 days earlier. As indicated above, DMAS believes that until the process improvements discussed above are operational, the actual time savings that they will contribute cannot be accurately determined. DMAS proposes to implement the changes as expeditiously as possible and that the potential time savings be evaluated by September 1, 2007, including the reduction in the submission deadline for nursing facilities.

6.3.3. Managing Workload by DMAS

In addition to the potential savings from efficiencies, DMAS can ask Clifton Gunderson to rearrange its workload to complete the desk audits sooner. Clifton Gunderson has indicated that it is reasonable for it to complete the desk audits 30 days earlier than the current deadline, at

least for 12/31 FYE providers during the rebasing year. In DMAS' view, shaving off more time through workload adjustments would result in excessive cost to DMAS, a potential burnout of audit staff (working overtime during the summer vacation season) and a possible impact on the quality of audits.

6.3.4. Use of As-Filed Data for Budgeting

The proposal that was discussed last year was to use as-filed data for budgeting purposes but settled data for final rebasing. As noted, this could lead to a potential discrepancy between appropriated funding and actual expenditures. DMAS compared as-filed and settled costs for a five year period (1999-2003) and determined that the discrepancy in those years was less than 1%, total settled costs were always lower than total as-filed costs and that the difference was reasonably predictable. In some years, settled indirect costs were higher than as-filed probably because the settlement process shifted costs from direct to indirect.

Table 8: Settled Costs as a Percent of As-Filed Costs 1999 - 2003

PFY	DIRECT	INDIRECT	TOTAL INDIRECT AND DIRECT
1999	99.67%	98.31%	99.53%
2000	98.48%	100.24%	99.48%
2001	98.48%	100.12%	99.17%
2002	98.77%	100.32%	99.49%
2003	98.97%	99.75%	99.37%
TOTAL	98.88%	99.77%	99.43%

As-filed data would normally be available in August but there are simple things that DMAS and Clifton Gunderson can do to make as-filed data available by mid to late June. Again, cost report filing delays would have an impact on the availability of as-filed data.

6.4. Conclusion

Work on the next rebasing, for FY 2009, will begin in the summer of 2007. At this time it appears questionable whether the proposed process improvements can, by that time, offer sufficient time gains in settling cost reports to allow use of CY 2006 rather than CY 2005 settled cost reports. Even if nursing facilities can file cost reports one month earlier, DMAS believes that settlement time can be reduced by perhaps one month, but probably not two. Therefore, use of a $2^{1/2}$ year look-back for the FY 2009 rebasing appears somewhat doubtful at

present. DMAS will continue to meet with the workgroup and evaluate this further. If process improvements yield more gains than expected, then this assessment could change.

As mentioned earlier in the report, the option remains of using as-filed data for budgeting purposes, and settled data for provider rate determination. This option has been discussed previously but not implemented. Nursing facility representatives continue to support this alternative as reasonable and responsible and ask that DMAS continue to evaluate its use within the ceiling rebase process.

The industry has made a significant commitment to support reducing the deadline for submitting cost reports by one month. DMAS will commit to evaluating the potential time savings from process improvement by September 1, 2007. If DMAS concludes that it can reduce the time for cost settlement by 60 days, DMAS will make a recommendation to the Administration for the 2008 General Assembly.

Appendix 1 – Members of the Workgroup

MEMBERS OF THE WORKGROUP

Name	Organization
Chris Bailey	Virginia Hospital and Healthcare Association
Chris Bennett	Goodman & Company
James Branham	DMAS Provider Reimbursement Division
Bill Burnette	First Health Services Corporation
Scott Crawford	DMAS Deputy Director of Finance & Operations
Beth Fariss	Commonwealth Care of Roanoke
Bob Gerndt	Bedford County Nursing Home
Jenny Greenwell	Riverside Convalescent
Diane Hankins	DMAS Provider Reimbursement Division
Hobart Harvey	Virginia Health Care Association
Walter Kmetz	Cambridge Healthcare Management
Carol Kroboth	Medical Facilities of America
Linda Lee	Clifton Gunderson LLP
William Lessard	DMAS Provider Reimbursement Division
Rena Roszell	DMAS Information Management Division
Mike Shannon	Friendship Retirement Community
Al Shrieves	Virginia Health Services
Dana Steger	Virginia Association of Nonprofit Homes for the Aging
Glenn B. Walker	Walker Healthcare Services Group
Richard Weinstein	Clifton Gunderson LLP

Appendix 2 – Nursing facility Electronic Cost Report Workgroup Agenda, Meeting Minutes, And Handouts

NURSING FACILITY COST REPORTING WORK GROUP MEETING 3/29/2006 MINUTES

March 30, 2006

Attendees:

DMAS Representatives:

Scott Crawford
William Lessard
Diane Hankins
James Branham
Rena Roszell

Clifton Gunderson:

Richard Weinstein
Linda Lee

Industry Representatives:

Hobart Harvey - VHCA
Al Shrieves - Virginia Health Services
Beth Fariss - Commonwealth Care of Roanoke
Bob Gerndt - Bedford County Nursing facility
Carol Kroboth - Medical Facilities of America
Chris Bailey - VHHA
Chris Bennett - Goodman & Company
Dana Steger - VANHA
Glenn B. Walker - Walker Healthcare Services Group
Jenny Greenwell - Riverside Convalescent
Mike Shannon - Friendship Retirement Community
Walter Kmetz - Cambridge Healthcare Management

Other Interested Parties: Mike Tweedy, Department of Planning and Budget

- Bill Lessard stated the goals of this workgroup is outlined in the budget mandate and indicated that an internal deadline of July 15th would be needed to allow for all internal and external review before the study is released to the Governor and the Chairman of the House Appropriations and Senate Finance Committees by September 1, 2006.
- Bill Lessard suggested that the workgroup meet monthly for the next several months to discuss the progress on the budget mandate.
- Hobart Harvey indicated that a goal of this workgroup should be the modernization of the cost reporting system. He indicated that the industry would like to consider a single cost reporting form that would be used by all nursing facilities. He also expressed that the industry would like a single cost reporting form that did not create more work for the facilities that is currently being done.
- Hobart Harvey expressed the desire that improvements in the current cost reporting lead to the possibility of a two-year look-back period for rebasing.
- Handouts were examined that provided high level information on timetables and responsibilities of the providers, DMAS and its fiscal agent, and the generalized processes that occur in a cost reporting cycle. Information was provided that demonstrated the number/percent of cost reports by provider fiscal year-end that require cost settlement.
- Bill Lessard indicated that there are facilities with single level of care and multiple levels of care. Facilities with single level of care use the "long" form of the PIRS 1090 to report cost report information while multiple levels of care facilities use the "short" version of the PIRS 1090 in conjunction with a CMS cost reporting form. He observed the facilities that use the long form

require less time to audit and provide more detailed information. Richard Weinstein noted that the information contained in the long form can be used for trend analysis and may help with variance analysis.

- An industry representative noted that a web-based standardized tool can be developed and remarked that Virginia Health Information has recently developed a standardized web-based tool for reporting financial information and encouraged DMAS to explore this model.
- Members of the workgroup began a discussion of the current cost reporting filing system. Processes discussed were Medicare filings, VHI filings of financial information, MMR report distribution, the CMI process, the audit process and general time frames for the availability of audited financial statements, and the need for more timely posting of ceilings and cost inflators.
- A representative of DMAS' cost settlement and audit agent provided statistics on the number of facilities and the time ranges of submission of cost report packages. He indicated that of the 238 cost reports due in 2005, 100 were received within 150 days or less (80 were deemed complete), 118 were received between 151 and 155 days, and 19 were received more than 5 days late (range is 11 to 221 days late). The industry was interested in knowing how many cost reports were received within 90 days of the provider's fiscal year-end.
- Action items that were suggested before the next meeting include:

A list of the current cost report schedules and the number of required or minimum data element in each schedule necessary for the provider to submit so that cost can be settled.

A presentation by DMAS representatives of on-going research of other state's cost reporting systems.

Completeness Review

The date for the next meeting will be announced.

AGENDA
NURSING FACILITY COST REPORTING WORKGROUP
VIRGINIA PREMIER'S CONFERENCE COOM
May 4, 2006, 1 PM

Welcome and Introductions

Discussion on Draft Nursing facility Cost Reporting Study Workplan/Outline

Conference Call with Chuck Briggs at HFS

Research into Other State's Current Cost Reporting Processes

- Description of Various Methods Used for Nursing facility Cost Reports
- E-Cost Reports
- Description of various Excel Cost Reports used by other states

Overview of April 12th Meeting with VHI

Discussion on the Two Types of Cost Reports Currently Used by Nursing facilities

- PIRS 1090 Short Form
- PIRS 1090 Long Form
- Sources of Data
- Similarities, Differences, and Statistics
- Overview of the Minimum Data Elements Needed for Cost Settlement

Completeness Review

MMR and Case Mix Index Secure Download Site

- HIPPA Compliance Decision
- First Health Process
- CMI Scores Report (Oracle)
- Implementation Issues

Next scheduled meeting June 1st 1pm.

5/4/2006 MINUTES

May 16, 2006

Attendees:

DMAS Representatives:
Scott Crawford
William Lessard
Diane Hankins
James Branham
Rena Roszell
William Burnette

Clifton Gunderson:
Richard Weinstein

Industry Representatives:
Hobart Harvey - VHCA
Beth Fariss - Commonwealth Care of Roanoke
Bob Gerndt - Bedford County Nursing Home
Carol Kroboth - Medical Facilities of America
Chris Bailey - VHHA
Chris Bennett - Goodman & Company
Glenn B. Walker - Walker Healthcare Services Group
Jenny Greenwell - Riverside Convalescent
Mike Shannon - Friendship Retirement Community
Walter Kmetz - Cambridge Healthcare Management
Becky Dolin – Health Financial System

Other Interest Parties: Mike Tweedy, Department of Planning and Budget

- Bill Lessard provided introductions and an overview of the agenda.
- A brief overview of the status of other state's cost reporting systems was presented by DMAS representatives.
- Bill Lessard conducted an overview of the VHI visit of agency personnel. The design of this web-based application was discussed with industry representatives. Concerns by industry representatives included the reliance of facilities on their current spreadsheet and "home-grown" analysis design that makes it more difficult or cumbersome for providers use, the ability of some facilities to upload into an improved cost reporting system, and the possibility of redundant data keying.
- Scott Crawford emphasized that the purpose of this study includes the publication of a report and options discussed in these meetings can be further analyzed, discussed, and developed after the submission of the report in September.
- An industry representative discussed the current design of the multiple spreadsheets requiring inefficient movement on the PIRS1090. He suggested the development of an upload worksheet that populates the multiple sheets be incorporated in the newly designed cost reports. Industry representatives also suggested facilities could be responsible to map data elements to the upload sheet using their current software data extracts.
- Bill Burnette indicated that it is very important to identify the business needs of an improved cost reporting system early in the discussions. He also expressed concern over security issues with passwords and data entry access in VHI's web-based design.
- Becky Nolin of Health Financial Systems (HFS) provided an overview of the HFS' development and marketing of CMS approved Medicare cost report software. HFS is the largest automated cost report vendor in the United States and assists health care facilities in meeting their federal and state governmental reporting requirements. HFS developed software applications are used by approximately 70% of the Commonwealth's Nursing facilities.

- DMAS provided an overview of the minimum data elements needed for cost settlement. This analysis reviewed all the cost reporting schedules, the sources of data, and the number of element in the "short" and the "long" PIRS1090 forms. Bill Lessard emphasized DMAS' desire to get information on the PIRS1090 "long" form for future analysis and variance development. Data elements from the Medicare Cost Report, MMR reports, CMI reports, and the ceilings and inflator table were reviewed.
- Bill Lessard led a discussion of the electronic forms that are currently used by the facilities. Specifically, the PIRS and the CMS Medicare forms were reviewed in detail. Hobart Harvey expressed the desire to implement as quickly as possible an input sheet that could be used by providers to map data as an input function to the current PIRS1090 forms. Hobart also expressed an interest in providing edit checks for current year data entries and a function that provided prior year comparisons. Genny Greenwell suggested providing a web-based application that providers could use to download prior year settled cost reports. Bill Lessard expressed the need for the ability to download Medicare data currently provided by the facilities on diskettes so variance analysis could be developed. This information can greatly expand the data elements that could be utilized during cost settlement.
- It was expressed by DMAS and the Nursing Facility Industry the desire to have only one application that accomplishes all the goals for improving the cost reporting process.
- Action items that were suggested before the next meeting include:

  A limited draft of several of the sections identified in the Nursing Home Electronic Study Workplan.

  A draft of various options in improving the cost reporting system including "Pros and Cons" of each identified option.

  An update on Florida's Sextant system.

The date for the next is June 1 at 1:00 pm in the DMAS Board Room.

AGENDA
NURSING HOME COST REPORTING WORKGROUP
DMAS' Board Room
June 1, 2006, 1 PM

Welcome and Introductions

Review of Business Needs

Review of MMR and Case-Mix Index Posting to the Web

Medicare Data

Option 1 - DMAS upload of Medicare cost report data

Option 2 – Facility adds Medicare data to cost report by submitting the PIRS "Long" form

Cost Report Options Overview

Option 1 - Enhanced PIRS 1090 Excel Spreadsheet

Option 2 - Enhanced PIRS 1090 Excel Spreadsheet with Embedded Visual Basic for Applications (VBA)

Option 3 - Interactive Web Application

NURSING FACILITY COST REPORTING WORK GROUP MEETING 6/1/2006 MINUTES

June 5, 2006

Attendees:

DMAS Representatives:
Scott Crawford
William Lessard
Diane Hankins
James Branham
Rena Roszell
William Burnette

Clifton Gunderson:
Richard Weinstein
Linda Lee

Industry Representatives:
Hobart Harvey - VHCA
Beth Fariss - Commonwealth Care of Roanoke
Carol Kroboth - Medical Facilities of America
Chris Bailey - VHHA
Chris Bennett - Goodman & Company
Glenn B. Walker - Walker Healthcare Services Group
Jenny Greenwell - Riverside Convalescent
Mike Shannon - Friendship Retirement Community
Walter Kmetz - Cambridge Healthcare Management
Becky Dolin – Health Financial System

Other Interest Parties: Mike Tweedy, Department of Planning and Budget

Absent: Bob Gerndt - Bedford County Nursing Home
Dana Steger - VANHA

- Bill Lessard provided introductions and an overview of the agenda.
- An overview of the Nursing Facility Industry and DMAS business needs was presented. Industry representatives expressed a desire for the development of a single web page that allows links for accessing ceilings and inflators, Case Mix summary information, and announcements explaining changes in cost reports. DMAS and the Nursing Facility community were in agreement that the business needs outlined accurately described a synopsis of issues described in the previous two workgroup meetings.
- Hobart Harvey described his perception that there may be difficulty in getting legislative support for using "As-Filed" cost reports to set prospective ceilings thereby reducing the three-year look-back period to a two-year look-back period. He suggested that the decision allowing change in the Administrative Code would most likely be made by individuals outside of the Nursing Facility Electronic Workgroup.
- Scott Crawford emphasized that the purpose of this study includes the publication of a report. Options discussed in these meetings can be further analyzed, discussed, and developed after the submission of the report in September. A draft will need to be prepared by mid-July to the Secretary of Health and Human Resources before submission to the Governor and the Chairman of the House Appropriations and Senate Finance Committees.
- Bill Lessard proposed three options for improving cost reports. Option 1 is an enhanced PIRS 1090 Excel spreadsheet that would add a data input worksheet that can populate the various schedules in the cost report. This spreadsheet allows providers to map to a single source all the data elements needed to complete the cost report.
- Option 2 is an expansion on Option 1 and includes embedded Visual Basic for Application (VBA). This option incorporates both formula-based and macro-based processes that include logical checks for data consistency and completeness.
- Option 3 expands Option 2 to a web-based environment. The same functionality that allows providers to upload into an Input worksheet described in Option 1 can be built in the web form. In addition, prior year comparisons and benchmarks may be included.

- Bill Lessard led a discussion on the pros and cons of each option. Richard Weinstein stated that he is working with representatives from DMAS to try to reduce the six-month review and settlement process by a month. He believes that once the efficiencies outlined in each of the options are in place, the completeness review may be shortened.
- A DMAS representative asked representatives from the Nursing Facility Industry to discuss ways they believed the industry could reduce the time needed from the close of a provider's fiscal year-end to submission to DMAS. Hobart Harvey stated that the "Payment for Services Committee" was meeting in Richmond on June 2, 2006. Hobart Harvey offered to initiate a discussion during this meeting with VHCA member on ways they believed providers could streamline the five-month allowance between fiscal year-end and submission to DMAS for cost settlement. He agreed to share details of the discussion with DMAS.
- Action items that were suggested before the next meeting include:

  A draft of report due to the Secretary of Health and Human Resources.

  A discussion document from Hobart Harvey on June 2, 2006 "Payment for Services Committee" members suggestions for reducing the time between fiscal year-end and cost report submission.

The date for the next is July 20 at 1:00 pm in the DMAS Board Room.

AGENDA
NURSING HOME COST REPORTING WORKGROUP
DMAS' Board Room
July 20, 2006, 1 PM

1. Welcome and Introductions

2. Overview of the "Look-Back" Period

3. Review of the Nursing Facility Cost Reporting Study

4. Open Discussion

NURSING HOME COST REPORTING WORK GROUP MEETING 7/20/2006 MINUTES

July 24, 2006

Attendees:

DMAS Representatives:
Scott Crawford
William Lessard
Diane Hankins
James Branham
Rena Roszell

Clifton Gunderson:
Richard Weinstein
Linda Lee

Industry Representatives:
Hobart Harvey - VHCA
Beth Fariss - Commonwealth Care of Roanoke
Carol Kroboth - Medical Facilities of America
Chris Bailey - VHHA
Chris Bennett - Goodman & Company
Bob Gerndt – Bedford County Nursing Home
Glenn B. Walker - Walker Healthcare Services Group
Jenny Greenwell - Riverside Convalescent
Mike Shannon - Friendship Retirement Community
As Shrieves – Virginia Health Services
Walter Kmetz - Cambridge Healthcare Management
Dana Steger - VANHA

Other Interest Parties: Mike Tweedy, Department of Planning and Budget
Absent: Mike Shannon – Friendship Retirement Community

- Bill Lessard provided introductions and an overview of the agenda.
- Hobart Harvey indicated that overall, the draft Nursing Facility Cost Reporting Study was well-written and presented very positively. The document was well constructed and the industry had only a few topics of discussion that they would like discussed during the meeting.
- Bill Lessard conducted a discussion on the two-year look-back period section of the report. He reviewed the background for the legislative mandate leading to a two-year look back and gave an overview of the last four rebasings including the specific look-back period used for each rebasing. Hobart Harvey suggested that the decision regarding the look-back period would most likely be made by individuals outside of the Nursing Home Workgroup.
- Bill Lessard reviewed the three options contained in the report for improving cost reports.

  Option 1 is an enhanced PIRS 1090 Excel spreadsheet that would add a data input worksheet that can populate the various schedules in the cost report. This spreadsheet allows providers to map to a single source all the data elements needed to complete the cost report.

  Option 2 is an expansion on Option 1 and includes embedded Visual Basic for Application (VBA). This option incorporates both formula-based and macro-based processes that include logical checks for data consistency and completeness.

  Option 3 expands Option 2 to a web-based environment. The same functionality that allows providers to upload into an Input worksheet described in Option 1 can be built in the web form. In addition, prior year comparisons and benchmarks may be included.
- Hobart Harvey strongly expressed his desire to see the end result of improving cost reports through the development of Option 3. DMAS indicated that they believed the progression of steps to an improved cost reporting process was through implementing Option 1 and Option 2, then evaluating the need or desire for Option 3 as the workgroup continues to meet and deliberate the technical implementation phase of the process. DMAS suggested that the committee continue to meet periodically to evaluate and test any revisions to the cost reports.

- A section by section review of the draft report was conducted. Members of the committee suggested changes or modifications to improve/clarify the results of the workgroup's deliberations. Members of the committee were asked to submit any additional comments or suggestions by Monday July 24 close of business.

Appendix 3 - Administrative Code References To Nursing facility Cost Reports

12VAC30-90-70. Cost report submission.

A. Cost reports are due not later than 150 days after the provider's fiscal year-end. If a complete cost report is not received within 150 days after the end of the provider's fiscal year, it is considered delinquent. The cost report shall be deemed complete for the purpose of cost settlement when DMAS has received all of the following (note that if the audited financial statements required by subdivisions 3 a and 7 b of this subsection are received not later than 120 days after the provider's fiscal year-end and all other items listed are received not later than 90 days after the provider's fiscal year-end, the cost report shall be considered to have been filed at 90 days):

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);

2. The provider's trial balance showing adjusting journal entries;

3. a. The provider's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, footnotes to the financial statements, and the management report. Multi-facility providers shall be governed by subdivision 7 of this subsection;

   b. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

   c. Schedule of investments by type (stock, bond, etc.), amount, and current market value;

4. Schedules which reconcile financial statements and trial balance to expenses claimed in the cost report;

5. Depreciation schedule;

6. Schedule of assets as defined in 12VAC30-90-37;

7. Nursing facilities which are part of a chain organization must also file:

   a. Home office cost report;

   b. Audited consolidated financial statements of the chain organization including the auditor's report in which he expresses his opinion or, if circumstances require, disclaims an opinion based on generally accepted auditing standards, the management report and footnotes to the financial statements;

   c. The nursing facility's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of cash flows;

d. Schedule of restricted cash funds that identify the purpose of each fund and the amount;

e. Schedule of investments by type (stock, bond, etc.), amount, and current market value; and

8. Such other analytical information or supporting documentation that may be required by DMAS.

B. When cost reports are delinquent, the provider's interim rate shall be reduced to zero. For example, for a September 30 fiscal year-end, payments will be reduced starting with the payment on and after March 1.

C. After the overdue cost report is received, desk reviewed, and a new prospective rate established, the amounts withheld shall be computed and paid. If the provider fails to submit a complete cost report within 180 days after the fiscal year-end, a penalty in the amount of 10% of the balance withheld shall be forfeited to DMAS.

12VAC30-90-75. Reporting form; accounting method; cost report extensions; fiscal year changes.

A. All cost reports shall be submitted on uniform reporting forms provided by the DMAS, or by Medicare if applicable. Such cost reports, subsequent to the initial cost report period, shall cover a 12-month period. Any exceptions must be approved by the DMAS.

B. The accrual method of accounting and cost reporting is mandated for all providers.

C. Extension for submission of a cost report may be granted if the provider can document extraordinary circumstances beyond its control. Extraordinary circumstances do not include:

1. Absence or changes of chief finance officer, controller or bookkeeper;
2. Financial statements not completed;
3. Office or building renovations;
4. Home office cost report not completed;
5. Change of stock ownership;
6. Change of intermediary;
7. Conversion to computer; or
8. Use of reimbursement specialist.

D. All fiscal year-end changes must be approved 90 days prior to the beginning of a new fiscal year.

Article 8
Prospective Rates

12VAC30-90-80. Time frames.

A. For cost reports filed on or after August 1, 1992, a prospective rate shall be determined by DMAS within 180 days of the receipt of a complete cost report. (See 12VAC30-90-70 A.) Rate adjustments shall be made retroactive to the first day of the provider's new cost reporting year. Where a field audit is necessary to set a prospective rate, DMAS shall have an additional 120 days to determine any appropriate adjustments to the prospective rate as a result of such field audit. This time period shall be extended if delays are attributed to the provider.

B. Subsequent to establishing the prospective rate DMAS shall conclude the desk audit of a providers' cost report and determine if further field audit activity is necessary. DMAS will seek repayment or make retroactive settlements when audit adjustments are made to costs claimed for reimbursement.

12VAC30-90-150. Cost report preparation instructions.

Instructions for preparing nursing facility cost reports will be provided by the DMAS.

Appendix 4 – A Complete Cost Report Package

A complete cost report package submitted by a nursing facility consists of:

1) Two complete and signed copies of Medicaid (PIRS 1090) cost reporting forms.
2) An electronic submission of the Medicare cost report (CMS 2540 for freestanding nursing facilities or CMS 2552 for hospital-based nursing facilities) on a disk and one complete and signed hard copy of the CMS 2540 or 2552. Only facilities that are Medicare certified are required to submit the Medicare cost report.
3) Audited financial statements.
4) A copy of the facility's working trial balance showing the adjusting journal entries.
5) A schedule which reconciles the trial balance to expenses claimed on each line of the CMS 2540, Worksheet A.
6) A schedule supporting the computation of all reclassification entries on CMS 2540, Worksheet A-6.
7) A schedule supporting the computation of all adjustments to expenses on CMS 2540, Worksheet A-8 or CMS 2552, Worksheet A-8.
8) A schedule which reconciles the trial balance of expenses to direct patient care nursing service costs on PIRS 1090, Schedule A-4.
9) Schedule of restricted cash funds that identify the purpose of each fund and the amount.
10) Schedule of investments by type (stock, bonds, etc.), amount, and current market value.
11) A detailed depreciation schedule for all depreciation expense claimed in the cost report.
12) A Schedule of Assets and a Schedule of Assets Reconciliation to the depreciation schedule.
13) One certified copy of CMS Form-339 Provider Cost Report Reimbursement Questionnaire.
14) Debt amortization schedule of all first year loans and any loans for which loan terms have changed during the current fiscal year.
15) Nursing facilities that are part of a chain organization must also file:
    a) A Home Office cost report.
    b) The nursing facility's audited financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings, and a statement of cash flows.

Appendix 5 – Completeness Review

COMMONWEALTH OF VIRGINIA
Department of Medical Assistance Services
Provider Reimbursement Division
Nursing Facility Cost Report
Completeness Review Checklist

The purpose of the completeness review is to ensure that all required documents have been submitted and completed in the provider cost report package in accordance with the Nursing facility Payment System to permit the clerical review, professional preview and review, and computation of prospective rate and cost settlement.

I have reviewed the Checklist for the cost report listed below:

PROVIDER NAME: ____

PROVIDER NUMBER: ____

FISCAL PERIOD: ____

COST REPORT RECEIVED DATE: ____

REVIEW DATE: ____

ANALYST: ____

CLIENT NUMBER: ____

*COMPLETE: YES*____________ *NO*_______________ *DATE DEEMED COMPLETE:*__________________

*INCOMPLETE (DATE OF LETTER REQUESTING ADDITIONAL INFORMATION):*_________________________

ANALYST REVIEW AND APPROVAL OF COMPLETENESS ______________________________
SIGNATURE

____
DATE

REVISED: 12/10/04
EFFECTIVE: FYE 9/30/93 FORWARD

PIRS 1090 SERIES SET ONE , Single Level of Care:

- _____*A* *Facility Description and Statistical Data*
- _____*A-2* *Certification by Officer or Administrator*
- _____*B* *Reclassification and Adjustment of Trial Balance of Expenses*
- _____*B-1* *Reclassifications*
- _____*B-2* *Analysis of Administrative and General Expenses*
- _____*B-4* *Adjustments To Expenses*
- _____*B-5, Pt. I* *Cost Allocation- Employee Benefits*
- _____*B-5, Pt.II* *Cost Allocation- Employee Benefits, Statistical Basis*
- _____*C* *Computation of Title XIX Direct Patient Care Ancillary Service Costs*
- _____*D* *Statement of Cost of Services from Related Organizations*
- _____*E* *Statement of Compensation of Owners*
- _____*F* *Statement of Compensation of Administrators and/or Assistant Administrators*
- _____*G* *Balance Sheet*
- _____*G-1* *Statement of Patient Revenues*
- _____*G-2* *Statement of Operations*
- _____*H, Pt. I* *Computation of Title XIX Base Costs and Prospective Rates/PIRS*
- _____*J, Pt. II* *Computation of Nursing Facility Medical Service Potential Prospective Reimbursement*
- _____*J, Pt. III* *Settlement Computations*
- _____*J, Pt. IV* *Analysis of Nursing Facility Interim Payments for Title XIX Services*
- _____*J, Pt. V* *Analysis of Nursing Facility Title XIX Patient Days*
- _____*J, Pt. VI* *Analysis of Nursing Facility Title XIX Charges*
- _____*J-1* *Calculation of NATCEP Reimbursement Settlement*
- _____*J-2* *Calculation of Criminal Record Check Costs Reimbursement*
- _____*K* *Debt and Interest Expense*
- _____*L* *Limitation on Federal Participation for Capital Expenditures Questionnaire*
- _____*N* *Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Programs (NATCEPS)*
- N/A *S* *Computation of CNA and NON-CNA Nursing Salary Increase Amount (DISCONTINUED EFFECTIVE 7/1/00)*
- _____*S-1* *Compilation of Nursing Salaries, Benefits, and Hours Related to Cost Reporting Period*

_____ *MAP-339 Provider Cost Report Reimbursement Questionnaire*

_____ *Debt Amortization Schedule for first year loans or loans in which loan terms changed during fiscal year (if applicable) per Schedule K*

_____ *Schedules supporting entries on B-1, B-2*

_____ *Schedules supporting entries on B-4*

_____ *Schedule of Assets*

_____ *Schedule of Assets Reconciliation*

PIRS 1090 SERIES SET TWO, Multiple Level of Care

_____*A-1* *Certification by Officer or Administrator*
_____*A-3* *Computation of Patient Intensity Reimbursement System Base Operating Costs*
_____*A-4* *Computation of Direct Patient Care Nursing Service Costs*
_____*C* *Computation of Title XIX Direct Patient Care Ancillary Service Costs*
_____*E* *Statement of Compensation of Owners*
_____*F* *Statement of Compensation of Administrators and/or Assistant Administrators*
_____*H . Pt. I* *Computation of Title XIX Base Costs and Prospective Rates/PIRS*
_____*J, Pt. II* *Computation of Nursing Facility Medical Services Potential Prospective Reimbursement*
_____*J, Pt. III* *Settlement Computations*
_____*J, Pt. IV* *Analysis of Nursing Facility Interim Payments for Title XIX Services*
_____*J, Pt. V* *Analysis of Quarterly Title XIX Patient Days*
_____*J, Pt. VI* *Accumulation of Title XIX Charges*
_____*J-1* *Calculation of NATCEPs Reimbursement Settlement*
_____*J-2* *Calculation of Criminal Record Check Costs Reimbursement*
_____*K* *Debt and Interest Expense*
_____*N* *Nurse Aide Training and Competency Evaluation Program Costs and Competency Evaluation Program (NATCEPs)*
N/A *S* *Computation of CNA and NON-CNA Nursing Salary Increase Amounts (DISCONTINUED EFFECTIVE 7/1/00)*

_____*S-1* *Compilation of Nursing Salaries, Benefits, and Hours Related to Cost Reporting Period*

_____*CMS-339* *Provider Cost Report Reimbursement Questionnaire*

_____*CMS 2540* *Skilled Nursing Facility Cost Report*

_____*ECR Disk (Electronic copy of Medicare approved 2540 Cost Reporting Forms)*

_____ *Schedule supporting cost claimed on Sch. A-4 and reconciliation to Working Trial Balance*

_____ *Debt Amortization Schedule for first year loans or loans in which loan terms change during fiscal year (if applicable) per Schedule K*

_____ *Schedule supporting the computation of all Worksheet A-6 Reclassifications*

_____ *Schedule supporting the computation of all Worksheet A-8 Adjustments*

_____ *Schedule of Assets*

_____ *Schedule of Assets Reconciliation*

PIRS 1090 SERIES SET THREE, Nursing Facility with Other Long Term Care Services:

CMS 2540:

- _____ *WS S-3* *Statistical Data*
- _____ *WS A* *Reclassification and Adjustment of Trial Balance of Expenses*
- _____ *WS A-6* *Reclassifications*
- _____ *WS A-7* *Capital Asset Balances*
- _____ *WS A-8* *Adjustment to Expenses*
- _____ *WS A-8-1* *Related Organization Cost*
- _____ *WS B Pt.I* *Cost Allocation - General Service Costs*
- _____ *WS B-1* *Cost Allocation-Statistical Basis*
- _____ *WS B Pt. II* *Allocation of Capital-Related Costs*
- _____ *WS C* *Departmental Cost Distribution*
- _____ *WS G* *Balance Sheet*
- _____ *WS G-1* *Changes in Fund Balance*
- _____ *WS G-2* *Statement of Patient Revenues & Expenses*
- _____ *WS G-3* *Statement of Operations*

PIRS 1090:

- _____ *A-1* *Certification by Officer or Administrator*
- _____ *A-3* *Computation of Patient Intensity Reimbursement System Base Operating Costs*
- _____ *A-4* *Computation of Direct Patient Care Nursing Service Costs*
- _____ *C* *Computation of Title XIX Direct Patient Care Ancillary Service Costs*
- _____ *E* *Statement of Compensation of Owners*
- _____ *F* *Statement of Compensation of Administrators and/or Assistant Administrators*
- _____ *H, Pt. I* *Computation of Title XIX Base Costs and Prospective Rates/PIRS*
- _____ *J, Pt. II* *Computation of Nursing Facility Medical Service Potential Prospective Reimbursement*
- _____ *J, Pt. III* *Settlement Computations*
- _____ *J, Pt. IV* *Analysis of Nursing Facility Interim Payments for Title XIX Services*
- _____ *J, Pt. V* *Analysis of Nursing Facility Title XIX Patient Days*
- _____ *J, Pt. VI* *Analysis of Nursing Facility Title XIX Charges*
- _____ *J-1* *Calculation of NATCEPs Reimbursement Settlement*
- _____ *J-2* *Calculation of Criminal Record Check Costs Reimbursement*
- _____ *K* *Debt and Interest Expense*
- _____ *N* *Nurse Aide Training and Competency Evaluation Program Costs (NATCEPs)*
- N/A *S* *Computation of CNA and NON-CNA Nursing Salary Increase Amount (DISCONTINUED EFFECTIVE 7/1/00)*
- _____ *S-1* *Compilation of Nursing Salaries, Benefits, and Hours Related to Cost Reporting Period*
- _____ *MAP 339 Provider Cost Report Reimbursement Questionnaire*
- _____ *Debt Amortization Schedule for first year loans or loans in which loan terms changed during fiscal year (if applicable) per Schedule K*
- _____ *Schedule supporting Cost Claimed on Schedule A-4 and Reconciliation to Working Trial Balance*
- _____ *Schedule supporting the computation of all Worksheet A-6 reclassifications*
- _____ *Schedule supporting the computation of all Worksheet A-8 adjustments.*
- _____ *Schedule of Assets*
- _____ *Schedule of Assets Reconciliation*

2. Review all requested schedules and attachments for legibility and request that provider must submit legible copies of any illegible schedules.

- _____ *Working Trial Balance*
- _____ *Reconciliation of Working Trial Balance and Cost Report*
- _____ *Detailed Depreciation Schedule*
- _____ *Schedule of restricted cash funds that identify the purpose and the amount of each fund*
- _____ *Schedule of investments by type (stocks, bonds, etc.), amount, and current market value.*

3. Nursing Facilities that are part of a chain organization must also file the following:

- _____ *Home Office Cost Report (CMS-287)*
- *nursing facility Financial Statements as follows:*
- _____ *Balance Sheet*
- _____ *Income Statement*
- _____ *Retained Earnings or Fund Balance*
- _____ *Statement of Cash Flows*

4. _____ The certification by officer or administrator of the facility must be included in the statement, be fully completed with date and each copy signed in ink (copy of the signature not permissible).

5. _____ Check that each schedule and any attached workpapers show the provider number.

6. _____ Check that two copies of the completed cost report have been submitted. Note only one copy is required for multi-level of care facilities which have to submit an ECR Disk.

Request from the provider in writing any incomplete information identified in steps 1-6.

Use the space below to document any further comments, phone conversations, etc.

____

____

____

____

____

7. ______If cost report shows amount due to Program, has provider enclosed payment?

YES___________ NO____________

If No - Send Provider a request for payment.

8. Summarize completeness review findings.

____

____

____

____

____

____

____

9. The following filing requirements shall be submitted no later than <u>150 days</u> after the provider's fiscal year-end:

<u>NON-CHAIN PROVIDERS</u>

___________ *"<u>Audited</u>" Financial Statements including a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), a statement of cash flows, auditor opinion letter with footnotes to the financial statements.*

__________ *Schedule which reconciles the audited financial statements' expenses to the trial balance submitted previously.*

__________ *Auditor's management report.*

<u>CHAIN PROVIDERS</u>

__________ *<u>Audited</u> "<u>consolidated</u>" financial statement of the chain organization.*

_________ *Auditor's management report.*

10. Request from the provider in writing any incomplete information not received by the appropriate due date in step 9.

11. Date filing requirements noted in step 9 were received ________________________.