907 KAR 1:065 and E
Material Incorporated by Reference

Medicare Provider Reimbursement Manual - Part 2 (Pub. 15-11)
Chapter 1. Cost Reporting - General (15-2-102) 102 and 104.
Cost Reporting Period
April 2000 Edition

Instructions for Completing the Medicaid Supplemental Schedules
November 2003 Edition

Supplemental Medicaid Schedules
November 2003 Edition

Schedule J Request for Reimbursement
November 2003 Edition

Filed October 31, 2003

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Long Term Care and Community Alternatives
275 East Main 6W-B
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COMMONWEALTH OF KENTUCKY

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IDER REIMBURSEMENT MANUAL – PART II (PUB. 15-II)
MANUAL

Chapter 1. Cost Reporting—General
[15-2-102] 102. COST REPORTING PERIOD

102. COST REPORTING PERIOD

For cost reporting purposes, Medicare requires submission of annual reports covering a 12-month period of operations based upon the provider's accounting year.

The provider may select any annual period for Medicare cost reporting purposes regardless of the reporting period it uses for other programs. Once a provider has made a selection and reported accordingly, it is required thereafter to report annually for periods ending as of the same date unless the intermediary approves a change in the provider's reporting period.

A cost reporting period under the program consisting of one of the following will be considered in compliance with the reporting periods cited above:

A. Twelve (12) successive calendar months,

B. Thirteen (13) four-week periods with an additional day (two on leap year) added to the last week or period to make it coincide with the end of the calendar year or month,

C. A reporting period which will vary from 52 to 53 weeks because it must always end on the same day of the week (Monday, Tuesday, etc.) and always end on (1) whatever date this same day of the week last occurs in a calendar month, or (2) whatever date this same day of the week falls which is nearest to the last day of the calendar month, even though this same day falls in the first week of the following month. A new provider beginning operations on January 1, 1974, and entering the program as of that date, could choose a reporting period beginning with that date and ending, for example, Wednesday, December 25, 1974. This provider's accounting period would end on the same day of the week (wednesday) and on whatever date that day of the week last occurs in the final month of the year. Alternatively, the provider could elect to end its first reporting period on January 1, 1975; this would be based on the election to end the period on the same day of the week which is nearest to the last day of the calendar year, even though the last day falls in the first week of the following month. The method selected must be consistently followed.

Rev. 1 1-3

[Rev. 15-2-01-1] 102.1 COST REPORTING 6-78 [Page 1-4]

A provider may prepare a short period cost report for part of a year under the circumstances described in §§102.1 through 102.3.

Where a provider did not furnish any covered services to Medicare beneficiaries or where it had low utilization of such services in a reporting period, a full cost report need not be filed. See §110 for an explanation of this procedure.

Providers in a chain organization, or other group of providers, are required to file individual cost reports as explained in §112.

102.1 *Initial Cost Reporting Period.*

In order to conform its initial Medicare cost reporting period to the annual reporting period it wishes to use, a provider may be permitted or required under the circumstances outlined below, to file its first Medicare cost report covering less than or more than a year (as defined below) of provider operations. The ending date (or day) chosen by the provider for its initial reporting period is presumed to be the ending date (or day) the provider elects for its subsequent annual reporting periods.

In the case of a newly constructed provider that enters the Medicare program during its initial business year, and in the case of providers that re-enter the Medicare program after a change of ownership, provider operations are considered to commence for cost reporting purposes when the first patient is admitted as an inpatient or receives outpatient services (hospital or SNF), when the first visit is rendered (home health agency), or when the first physical therapy or speech pathology service is rendered (rehabilitation agency, clinic, public health agency). Therefore, a provider's initial cost reporting period may not start before the beginning of the month in which it first renders patient care services which could be covered under the program.

A. Established Providers

ovider is considered to be an established provider upon its entry into the Medicare program if it s in operation at least one year prior to the effective date of its participation. An established provider may file its initial Medicare cost report covering a period of at least one month of provider operations under the program, but not to exceed 13 months of operations under the program.

If an established provider wished to report on a calendar year basis and entered the program on July 1, 1977, it could have filed its initial cost report for the period beginning January 1, 1977, and ending December 31, 1977, or alternatively, for the period beginning July 1, 1977, and ending December 31, 1977.

B. New Providers

A provider (including a provider that changes ownership) is considered to be a new provider upon its entry into the program if it enters the program at the inception of or *during* its initial business year. A new provider may file its initial cost report covering a period of at least one month of provider operations under the program but not to exceed 13 months of operations under the program.

Rev. 1 1-4

[Rev. 15-2-01-1] 6-78 COST REPORTING 102.2 [Page 1-5]

If the provider enters the program at the same time that it begins operations, the initial cost reporting period will begin with the effective date of participation. For example, a hospital that began operations and entered the program on September 15, 1976, and wished to adopt a reporting period ending date of September 30, must have filed its initial cost reporting covering the period from September 15, 1976, through September 30, 1977. It could not have filed the report for the 15-day period ending September 30, 1976.

If a new provider wished to report on a calendar year basis, began operations on February 1, 1977, and entered the program on July 1, 1977, it could have filed its initial cost report for the period beginning February 1, 1977, and ending December 31, 1977, or, alternatively, for the period beginning July 1, 1977, and ending December 31, 1977.

e provider does not begin operations until after the effective date of its entry into the program, the initial rting period will begin with the first day of the month in which patient care service begins. For example, a hospital which entered the program effective August 1, 1977, but did not begin delivering patient care services until September 15, 1977, and wished to adopt a reporting period ending date of September 30, could have filed its initial cost report covering a period beginning September 1, 1977, and ending on either September 30, 1977, or September 30, 1978.

102.2 *Cessation of Participation in Program.*

A. General

When a provider ceases to participate in the health insurance program, it must file a cost report covering a period under the program up to the effective date of cessation of participation in the program. Depending on the circumstances involved in the preparation of the provider's final cost report, the provider may file the cost report for a period of not less than 1 month or not more than 13 months.

B. Payment for Services After A Provider Ceases to Participate in the Program (Termination, Expiration, or Cancellation of the Provider Agreement)

1. Hospital and SNF

Effective October 30, 1972, a hospital or skilled nursing facility whose provider agreement either voluntarily or involuntarily ceases (not a change of provider ownership) may be reimbursed under the agreement for up to 30 days of covered Part A inpatient services furnished on or after the effective date of cessation of participation in the program to patients who are admitted *before* the cessation date. No payment will be made for such services to patients admitted on or after the cessation date.

Rev. 1 1-5

[Rev. 15-2-01-1] 102.3 COST REPORTING 6-78 [Page 1-6]

No payment will be made for hospital services to outpatients or for outpatient physical therapy or ech pathology services furnished by a provider on or after the effective date of cessation. ever, payment may be made under Part B to a nonparticipating provider for the medical and ther health services which it furnishes in compliance with specified requirements explained in the Nonparticipating Domestic Hospital Supplement (HIM-30) of the Hospital Manual (HIM-10).

2. Home Health Agency

ment can continue to be made to home health agencies for covered Part A and Part B home health services furnished through the calendar year in which the cessation is effective where the plan of treatment was established prior to the date of cessation. No payment will be made for home health services furnished under a plan or treatment established on or after the cessation date.

3. Interim Rate

Payment for allowable covered services after cessation of participation will be made at an interim rate not to exceed the interim rate developed on the basis of the latest cost report submitted by the provider. No adjustment should be made to this interim rate until the cost report ending with the date of cessation has been audited, unless the intermediary obtains information that would justify a change in the interim rate. Settlement for such services will be on the basis of a per diem rate developed from Medicare data appearing in the provider's final settled cost report ending with the date of cessation. No cost report will be required for the services furnished following cessation.

102.3 *Changing of Cost Reporting Periods.*

A provider must adhere to the cost reporting period initially selected unless a change has been authorized in writing by its intermediary. For the change to be effective, the provider's written request must be received by the intermediary 120 days or more before the close of the reporting period which the change proposes to establish. The intermediary should notify HCFA of the authorized change 30 days or more before the close of the reporting period which the change proposes to establish to allow the Administration sufficient time to adjust its records. For example, where a provider wishes to change the ending date of its cost reporting period from December 31 to July 31, the provider's request for a change must be received by the intermediary 120 days or more before the July 31 date on which the change is to take effect.

Such a change may be made only after the intermediary has established that the reason is consistent with the purposes and intent of the program. Under the foregoing circumstances, the provider may file a cost report for a period of not less than one month or not more than 13 months. A change which is made primarily to maximize reimbursement in any one period would not be acceptable.

Rev. 1 1-6

[Rev. 15-2-01-18] 06-96 COST REPORTING 104 [Page 1-7]

Providers owned and/or operated by governmental entities using fiscal year ending dates established by local law, may require changes in the reporting year ending dates as a result of legislative action. In such situations, a provider with the approval of its intermediary may revise its cost reporting period to conform to the new fiscal year established by the applicable lawmaking body. A transitional period report covering the period initially affected by the change should be filed, provided it covers a period of not less than one month or more than 13 months.

VIDER REIMBURSEMENT MANUAL – PART II (PUB. 15-II)
MANUAL

Chapter 1. Cost Reporting—General
[15-2-104] 104. COST REPORT DUE DATES

104. ▸COST REPORT DUE DATES◂

Cost reports are required to be filed following the close of a provider's reporting period. (See §102.) The due dates for cost reports are as follows:

A. Provider Continues to Participate in Program

1. Cost reports are due on or before the last day of the fifth month following the close of the cost reporting period.

2. No extensions will be granted except when provider's operations are significantly adversely affected due to extraordinary circumstances over which the provider has no control. An example would be a flood or fire that forces a provider to cease operations and to transfer its patients temporarily to other providers outside of the impacted area. The intermediary would still be required to obtain HCFA approval.

3. The provider must receive the Provider Statistical and Reimbursement Report(PS&R) on or before the 120th day. If the intermediary is late mailing the PS&R, the provider will have 30 days from the date of receipt of the PS&R to file its cost report, even if it extends beyond the 5 month due date. No interest will be assessed against the provider for filing the cost report beyond the 5 month period if the cost report is late due to late receipt of the PS&R.

4. A cost report is considered to be timely filed if the cost report is postmarked by the due date. This requirement applies regardless of whether the provider furnishes a hard copy or a diskette sion. If a cost report is due on a Saturday, Sunday, or Federal holiday, the cost report is sidered timely filed if postmarked by the following working day.

B. Provider Agreement to Participate in Program Terminates (Voluntarily or Involuntarily) or Provider Experiences Change in Ownership

1. Cost reports are due no later than 5 months following the effective date of the termination of the provider agreement or the change of ownership.

2. Items 2 through 4 in subsection A will apply.

Instructions for Completing the Medicaid Supplemental Schedules

All Medicaid Supplemental Schedules must be accompanied by a working trial balance and audited financial statements (if applicable).

Schedule NF-1 – Provider Information
Enter in the appropriate information. Choose whether the cost report is in a leap year or a regular 365 day year. Note that the cost report must have an original signature by an officer or administrator of the facility.

Schedule NF-2 – Wage and Salary Information
This schedule records a facility's labor costs.

The pay period starting date should be the first day of the first payroll period in the provider's fiscal year. Likewise, the end date shall be the final day of the last payroll period in the fiscal year.

Under wage information, the hours paid includes vacation pay, sick leave, bereavement, shift differential and holidays in *addition to* time engaged in for regular business activity. Hours worked, in contrast, are only those hours that the employee spent at the facility in normal work duties. Wages paid should include all compensation paid to the employee, including time worked, time in training, vacation, and sick time.

Expenses incurred with outside businesses for temporary nursing staff should be placed under contracted services. For each nursing category, enter the hours worked by the contract employees and the amount charged by the contracting business for wages paid. Hours paid and hours worked will differ only if the contract staff engaged in training while being employed at the facility.

Benefits paid by the facility for *all employees* (nursing staff, administrative, etc.) should be included under Section C: the facility's contribution for health insurance, life insurance, etc. would be listed under these categories.

Schedule NF-3 – Staff Information
On an annual basis the Department for Medicaid Services shall select a seven day period in which the facility records information regarding their staffing levels and patient days.

1. Record the number of residents in your facility in the Resident Census section. This includes *only* those full-time residents in the certified nursing facility section.

2. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.

3. Continue this throughout the seven day survey period.

Schedule NF-7 – Allocation Statistics

A. Section A – Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Lines 1 through 6. The sum of lines 1 through 6 are totaled on line 7.

2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 are summed and totaled on line 7.

3. Column 3. The Medicaid percentage in column 5 is calculated by dividing KMAP charges in column 4 by total charges in column 1. Percentages shall be carried to four decimal places (*i.e.*, XX.XXXX%).

B. Section B – Occupancy Statistics.

Certified Nursing Facility. Use the Bed Days Available worksheet in Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. Temporary changes due to alterations, painting, etc., do not affect bed capacity.

2. Line 3. Total licensed bed days available shall be determined by multiplying the number of beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, use actual bed days.

3. Line 4 and 6. Total patient days should be entered in.

Schedule NF–8 – Miscellaneous Information
All providers must complete sections A and B.

SCHEDULE NF-1
PROVIDER INFORMATION

)ER NAME: _____ _____

PROVIDER NUMBER: _____

period from _____ to _____

Leap Year ☐ 366 365 ☐

Street Address: _____
P.O. Box: _____
City: _____
State: _____
Zip Code: _____

Phone: ( ) _____
Fax: ( ) _____

on by Officer of Facility
Y CERTIFY that I have examined the accompanying Kentucky
Cost Report for the period ended 01/01/2000
to the best of my knowledge and belief, they are true and
atements prepared from the books and records of 0
ance with applicable program directives, except as noted.

(Print) _____
Officer or Administrator of Facility

(Signed) _____
Officer or Administrator of Facility

_____
Title

SCHEDULE NF-2
WAGE AND SALARY INFORMATION

PROVIDER NAME:
PROVIDER NUMBER:

FYE: 01/01/2000

Pay period start date: _____ End date: _____

A. Wage Information

Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	$0
B. LPN	0	0	$0
C. Aides	0	0	$0
D. Director of Nursing	0	0	$0
E. Activities	0	0	$0
F. Medical Records	0	0	$0
G. Dietary	0	0	$0
H. Housekeeping/Laundry	0	0	$0
I. Social Services	0	0	$0
J. Maintenance	0	0	$0
Total	0	0	$0

B. Contracted Services

Cost Category	Hours Paid	Hours Worked	Wages Paid
A. RN	0	0	$0
B. LPN	0	0	$0
C. Aides	0	0	$0
Total	0	0	$0

C. Benefits Paid for by Nursing Facility

	Totals taken from FYE 01/01/2000
Health Insurance	$0
Life Insurance	$0
Retirement	$0
Workers Compensation	$0
[illegible]	$0
Total	$0

SCHEDULE NF-3
STAFF INFORMATION

FYE: 01/01/2000

PROVIDER NAME:
PROVIDER NUMBER:

	Number of Patient Days						
	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
Patient Census	0	0	0	0	0	0	0
	Number of Staff on Payroll						
Staff Category	09/13/99	09/14/99	09/15/99	09/16/99	09/17/99	09/18/99	09/19/99
RN							
RN Staffing - Day	0	0	0	0	0	0	0
RN Staffing - Evening	0	0	0	0	0	0	0
RN Staffing - Overnight	0	0	0	0	0	0	0
LPN							
LPN Staffing - Day	0	0	0	0	0	0	0
LPN Staffing - Evening	0	0	0	0	0	0	0
LPN Staffing - Overnight	0	0	0	0	0	0	0
Aides							
Aide Staffing - Day	0	0	0	0	0	0	0
Aide Staffing - Evening	0	0	0	0	0	0	0
Aide Staffing - Overnight	0	0	0	0	0	0	0
Food Service							
Food Service Workers- Day	0	0	0	0	0	0	0
Food Service Workkers - Evening	0	0	0	0	0	0	0
Support Personnel							
Housekeeping/Laundry Service Workers	0	0	0	0	0	0	0
Social Services Worker	0	0	0	0	0	0	0
Activities Worker	0	0	0	0	0	0	0
Medical Records Worker	0	0	0	0	0	0	0
Maintenance Worker	0	0	0	0	0	0	0
Director of Nursing	0	0	0	0	0	0	0

SCHEDULE NF-7
ALLOCATION STATISTICS

PROVIDER NAME:
:OVIDER NUMBER:

FYE: 01/01/2000

ANCILLARY CHARGES

	(1) TOTAL	(2) MEDICAID	(3) MEDICAID %
HYSICAL THERAPY	$0	$0	0.0000%
RAY	$0	$0	0.0000%
ABORATORY	$0	$0	0.0000%
XYGEN/RESP. THERAPY	$0	$0	0.0000%
PEECH	$0	$0	0.0000%
OCUPATIONAL THERAPY	$0	$0	0.0000%
OTAL	$0	$0	

OCCUPANCY STATISTICS

	(1) CERTIFIED NURSING FACILITY	(2) NON-CERTIFIED NURSING FACILITY	(3) OTHER LONG-TERM CARE
ED BEDS AT GINNING OF PERIOD	0	0	0
CENSED BEDS AT ND OF PERIOD	0	0	0
D DAYS AVAILABLE	0	0	0
TAL PATIENT DAYS	0	0	0
OCCUPANCY	0	0	0
MAP PATIENT DAYS	0		
KMAP OCCUPANCY	0		

ED DAYS AVAILABLE - CERTIFIED NURSING FACILITY ONLY

gining Date	Ending Date	Days		Beds		Bed Days Available
01/01/2000		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
		0	X	0	=	0
	TOTAL DAYS	0		TOTAL BED DAYS AVAILABLE		0

SCHEDULE NF-8
MISCELLANEOUS INFORMATION

PROVIDER NAME:
ROVIDER NUMBER:

FYE: 01/01/2000

Current Ownership

t the current owners and the percent owned. If the facility is corporately owned, the officers of the company and their respective title.

Name	Percent Owned

e facility had a change of ownership in the past fiscal year?
ge of ownership is defined as the transfer of the assets of a ity. The sale of stock in a facility does not constitute a change wnership.

Yes ☐ No ☐

s, indicate the new owners and the percent owned. If the facility is corporately owned, he officers of the company and their respective title.

Name	Percent Owned

SCHEDULE J
REQUEST FOR REIMBURSEMENT
RELATED TO RESPIRATORY THERAPY
JULY 1 THROUGH SEPTEMBER 30, 2003

FACILITY NAME: _____

PROVIDER NUMBER: _____

RECIPIENT NAME	MAID NUMBER	CHARGES FOR SERVICES	CHARGE TO COST RATIO	COST FOR SERVICES

TOTAL COST PER FACILITY $ _____