FY16 NF Cost Report Filing FAQ's

Census

The instructions say a pdf of the entire midnight census should be submitted. The question is whether a summary of the midnight census can be submitted with the cost report?

Response: A Census Summary is acceptable at the time of filing the Cost Report. DMA will request an entire census if needed.

Adult Care Home Census

The Supplemental Schedules do not have a column for reserve or therapeutic leave ACH days. How should these be identified?

Response: Adult Care Home is a single column for Adult Care Home inpatient days whose total will agree to the CMS cost reporting schedules.

Capital Data Survey

How will capital additions purchased be handled? Added to next year's CDS?

Response: Capital Data Survey will be delinked from the cost report.

Schedule F

Lines 2 and 3-Most of our reports will have training and travel coded to every cost center. As such we need more than 3 lines for each of these categories. Any idea how to handle? I tried to insert lines but couldn't.

Response: Effective with Version 4.0 for Schedule F only, to allow for more than one Working Trial Balance general ledger account, additional lines can be added by using the following; click on the Options tab just above the Schedule and below the tool bar, then click on enable this content. Once this is completed, above the tool bar a tab called Add-ins will appear, click on this tab and a box will appear indicating Add-row / Hide Last Extra Row. Select the line where additional row is needed, then select Add-row and the row will be created.

Lines 19, 20, and 21. MDS Coordinator, QA Coordinator, and In-service Coordinator are shown as indirect. Based on the last chart of accounts I printed out a few weeks ago, these were identified as direct costs. Is it correct to show these as indirect?

Response: Those which are non-case mixed; we will map them to a direct cost. Indirect care is a category title.

Schedule G

The instructions say if the provider has any of the following levels of care coded to routine cost centers, identify ….. Do the instructions really mean routine cost centers, or do they mean routine OR general service cost centers? For example, if MRPT cost is coded to A and G, a general service cost center, should the cost be identified here?

Response: Yes – MRPT on Schedule G is meant for routine and general service cost. If MRPT is included on the CMS forms in a general service cost center, they must identify the amount and cost center on Schedule G, but no data is required on G-1.

If costs identified in non routine cost centers is to be identified, as with the F schedules, there are not enough lines. For instance, we would normally have MRPT costs identified in Capital, OMP, Admin and Gen, and Nursing on the Medicare cost report. Any suggestion on how to handle if that is the case?

Response: The provider may submit a supplemental spreadsheet with the same Schedule G data elements for the additional lines.

Schedule G-1

The instructions state that rows 36, 37, 43, and 44 are MPRT statistics if coded to a routine cost center. Whether coded to a routine or general service cost center, MRPT will not have any statistics. Can you elaborate on this/provide suggestions on what to do?

Response: Yes – MRPT on Schedule G is meant for routine and general service cost. If MRPT is included on the CMS forms in a general service cost center, they must identify the amount and cost center on Schedule G, but no data is required on G-1.

A provider has identified MRPT cost on Schedule G which has been coded to a routine cost center on the CMS cost reporting forms., I am breaking out our MRPT costs related to our facility van, driver wages, and contracted transport. But I'm not sure what needs to be completed on Schedule G-1 for this. What should be placed on Schedule G-1?

Response: Supplemental Schedule G is asking providers if they have Vent, Head Injury, Geropsych, or MRPT coded on the Medicare cost reporting forms to a Routine Cost Center (or General Service Cost Center). If so, they need to segregate and identify the cost associated with these levels of care. This will be the information necessary to carve out these other levels of care from cost coded to routine cost centers (or General Service Cost Centers) on Worksheet A of the CMS forms.

Response Continued on Next Page

Response: Supplemental Schedule G-1 recognizes that if the provider has coded Vent, Head Injury, Geropsych, or MRPT to a routine cost center, then steps need to be taken to segregate and identify how much of each stepped down General Services cost is applicable to these levels of care. Therefore, Supplemental Schedule G-1 is directing providers to break out each statistic on W/S B-1 which pulls cost to the routine cost center between the levels of care.

General

An adjustment made on the Medicare cost report A-8-1 at least theoretically in the same amount that would be made if a related organization cost report would be prepared, but the Medicare cost report essentially removes profit on the Medicare cost report since Medicare has never forced the provider to file a related organization cost report. So the related organization cost report would not support what was submitted on the Medicaid supplemental forms, but would support what was submitted on the Medicare cost report filed with the Medicaid cost report. In this specific case, should a related org. cost report be filed?

Response: If the provider has a home office, they must file the CMS 287 (Home Office) cost reporting forms pursuant to CMS Publication 15, Section 3903. The Medicaid cost reporting instructions require the provider to submit a hardcopy of the CMS 287 to DMA with the facility cost report.

If the provider has a related organization which does not fall subject to CMS 287 requirements, they must complete Worksheet A-8-1 in accordance with Medicare cost reporting principles. These entries are subject to audit to verify they are in compliance with reporting related organization costs.