COST REPORTS

Intermediate Care Facilities for individuals with Intellectual Disabilities (ICF/IID) providers are required to file annual cost reports to the Louisiana Department of Health (LDH) in accordance with instructions as follows:

- Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report including any supplemental schedules designated by LDH; and

- Separate cost reports must be submitted by central/home office(s) and habilitation programs when costs of those entities are reported on the facility cost report.

Cost reports must be prepared in accordance with cost reporting instructions adopted by the Bureau of Health Services Financing (BHSF) using definitions of allowable and non-allowable cost contained in the *Medicare Provider Reimbursement Manual* (HIM-15) unless other definitions of allowable and non-allowable cost are adopted by BHSF.

Each provider must submit an annual cost report for fiscal year ending June 30. The cost reports must be filed within ninety (90) days after the state's fiscal year ends.

Exceptions

Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements cited during the Health Standards Section annual survey or during a complaint investigation in accordance with LAC 50:I.5501, et seq. The floor shall be applied in the cost report year of the violation.

For providers receiving pervasive plus supplements and other beneficiary specific adjustments to the rate in accordance with Section 26.11 – Other Beneficiary Specific Adjustments to the Rate, the facility wide direct care floor is established at 94 percent of the per diem direct care payment, the pervasive plus supplement, and other beneficiary specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a beneficiary specific rate adjustment.

In no case, however, shall a facility receiving a pervasive plus supplement and/or beneficiary specific rate adjustment have total facility payments reduced to less than a safe harbor percentage of 104 percent of the total facility cost as a result of imposition of the direct care floor, except in connection with an administrative penalty as noted below for repeat non-compliance with direct care floor requirements.

For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to BHSF the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to BHSF upon submission of the cost report.

Effective for dates of service on or after July 1, 2022, if a provider receiving complex care or pervasive plus add-on payments has facility payments reduced as a result of imposition of the direct care floor, the Department may, at its discretion, levy a non-refundable administrative penalty separate from any other reduction in facility payments. The administrative penalty is not subject to any facility specific safe harbor percentage and is calculated solely on the final reduced payment amount for the cost report period in question.

The Department may impose sanctions for noncompliance with Medicaid laws, regulations, rules, and policies. Facilities that have payments reduced as a result of the imposition of the direct care floor with consecutive subsequent years of reduced payments, shall incur the following safe harbor and administrative penalties:

Consecutive Cost Report Period with Reduced Payments	Administrative Penalty Levied on Reduced Payments	Safe Harbor Percentages
1st Year	0%	104%
2nd Year	0%	102%
3rd Year	5%	100%
4th Year and Onwards	10%	100%

At its discretion, the Department may terminate provider participation in the complex care or pervasive plus add-on payment programs, as a result of imposition of the direct care floor.

The direct care floor recoupment and/or administrative penalty assessed as a result of a facility not meeting the required direct care per diem floor is considered effective thirty (30) days from the issuance of the original notice of determination. Should an informal reconsideration be requested,

the recoupment and/or penalty will be considered effective thirty (30) days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of the recoupment (s) and/or penalty.

Upon completion of desk reviews or audits, facilities will be notified by BHSF of any changes in amounts due based on audit or desk review adjustments.

All costs submitted on cost reports must be beneficiary care related. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The provider contract contains a penalty provision for cost reports with all forms completed, not received on a timely basis. (See Section 26.14 – Sanctions and Appeals for additional information regarding sanctions).

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. All ICF/IID providers receiving Medicaid funding will maintain, for five years following submission of the cost report, all financial and statistical information necessary to substantiate cost data. Providers are required to make these records available upon request to representatives of LDH the State of Louisiana, or the United States Department of Health and Human Services (DHHS).

Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, basis for apportioning costs, etc.) that pertain to the reported costs.

Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing. The census records must include totals for each resident for each month and also must reflect monthly totals by payor-type. Census days must be segregated between Medicaid and other payors. All census occurrences must be reflected on the census document. Supporting documentation for admission, discharges, death, hospital and home leaves must be maintained and should include dates and times.

Each facility receiving funds from other public sources must report such on the cost report form, even if the funding is provided for other programs, and make available additional information on this funding as requested by LDH.

The data submitted on the cost report will reflect Balance Sheet and Income Statement information for the twelve-month period being submitted. Cost data will be appropriately adjusted for rate setting purposes.

All costs submitted on cost reports must be care related. A knowing inclusion of costs in violation of this requirement, as well as other requirements of the HIM-15, could subject the provider to criminal prosecution under La. R. S. 14:70.1 or La. R. S. 14:133.

For allocated or shared costs, a separate cost report must be completed showing the total costs prior to allocation. The method of allocation and the percentage of allocation to each individual provider must also be shown.

Providers are required to submit the following documents with their cost report submission:

- Cost Report;
- Detailed fixed asset depreciation schedule;
- Copies of leases;
- Working Trial Balance; and
- Central office and habilitation schedules.

Cost Report Adjustments

The following guidelines are provided to aid in determining allowable and non-allowable costs for rate setting and cost reporting purposes. Allowable costs generally require no adjustment when reported. Non-allowable costs should be reflected as such by an adjustment to the proper cost category on the cost report schedule.

Salaries

Salaries are an allowable cost if:

- The number of employees is based upon individual facility requirements determined in conjunction with LDH Licensing and Certification and the appropriate program office;
- Functions performed are related to the provision of care in the facility; and
- Individual salaries do not exceed the maximum allowable under Louisiana State Civil Service Salary Schedules for comparable positions. The salary maximums are published periodically by LDH.

Taxes

Taxes are an allowable cost with the following specific exemptions:

- Federal income or excess profit tax;
- State income or franchise tax;
- Taxes relating to financing;
- Special assessments (this would be capitalized and amortized);
- Taxes for which exemptions are available;
- Taxes on property not related to direct beneficiary care; and
- Self-employment (FICA) taxes applicable to individual proprietors, partners, etc.

Advertising Costs

The following types of advertising costs are allowable:

- Classified newspaper advertising to recruit personnel or solicit bids; and
- Telephone "Yellow page" advertising, except in the event that such advertisement is promotional in nature. Allowable cost is limited to the cost of a 1" x 1" size advertisement.

Costs for fund raising, public relations and promotional advertising are income producing items which should be offset against income provided.

Bad Debts

Bad debts, charity and courtesy allowances are deductions from revenue and are not an allowable cost.

Dues

Dues are not an allowable expense with the exception of dues to one’s professional organizations.

Interest Expense

Generally, necessary and proper interest on both current and capital indebtedness is an allowable cost.

"Necessary" requires that interest be:

- Incurred on a loan made to satisfy a financial need of the provider;
- Incurred on a loan reasonably related to patient care; and
- Reduced by investment income.

"Proper" requires that interest be:

- Incurred at a rate not in excess of what a prudent borrower would have to pay; and
- Paid to a lender not related through control or ownership or personal relationship to the provider. Exceptions are allowable only in accordance with HIM-15, Section 218.

Attorney Fees

Only actual and reasonable attorney fees incurred for non-litigation legal services which are directly related to beneficiary care will be allowed. Monies paid to an attorney or a law firm as a retainer, rather than as legal fees for services actually performed, are non-allowable expenses.

Health Costs

In all of the examples of allowable expenses below, it is required that a facility will attempt to utilize public resources prior to employing or contracting with totally private medical providers or purchasing medical supplies.
Examples of public resources would include Medicaid medical providers for eligible individuals:

- State or city supported clinics and hospitals for immunizations;
- Examinations and other screening services;
- Emergency treatment; and

- On-going special treatment needs such as:
    - Handicapped Children's Program for orthopedic problems;
    - Charity Hospital system for dialysis needs;
    - Mental health clinics for counseling and medication;
    - Local education agencies for evaluation;
    - Physical therapy;
    - Occupational therapy and speech therapy services for individuals under age 22; and
    - Local civic organizations for glasses, wheelchairs, etc.

Medical services provided by the facility that may be included for cost reporting purposes if documented that these services are not available by Title XIX providers or other public resources include:

- Periodic medical examinations that include vision, hearing, and routine screening and laboratory examinations as determined necessary by the physician;
- Immunization;
- Tuberculosis control;
- Physician services, minimally to supervise the general health conditions and practices of the facility and be available for emergencies on a 24-hour, seven days a week basis;
- Initial and periodic dental examinations and routine treatment, including provisions for emergency treatment at all times;
- Dental hygiene program;
- Psychological testing and counseling when provided routinely to all beneficiaries;

- Psychiatric examination and treatment when provided routinely for facility beneficiaries; and

- Medical appliance upkeep, repairs, and purchase of medical supplies for the general facility population.

The cost for the above services will be limited to that which is considered reasonable not to exceed the Medicaid payment where applicable.

Income Producing Expenses

Any income from such items as sale of medical records, sale of scrap and waste, rental of space, etc. (when the item was included as an allowable cost) shall be offset. Purchase discounts, allowances, and refunds will be recorded as a reduction of the cost to which they relate.

Transportation Costs

Allowable costs include transportation intrinsic to the well-being of the beneficiary, including but not limited to visits with relatives, prospective foster or adoptive parents, and other activities or events that are an integral part of the 24-hour program and not available through another resource. Expenses for an attendant, when required, may be allowed if not already charged to the State's program under Titles XIX, XX, IV-B, or other publicly funded programs.

Other Non-Allowable Expenses

The following is a list of other non-allowable expenses:

- Appraisal costs;

- Capital expenditures;

- Collection costs;

- Payments to directors on the facility's Board of Directors. This does not include reimbursement for expenses;

- Educational costs;

- Fines, penalties, judgments or settlements of any kind;

- Any costs not related to care in the facility;
- Payments made by the facility as gifts, assessments or paybacks to parent organizations;
- Expenses reimbursable by other State or Federally funded programs;
- Vending machine expenses;
- Expenses for gifts, flower and coffee shops; and
- Depreciation of equipment used to secure self-generated revenue.

Start-up Costs

In the period of developing a facility's ability to furnish beneficiary care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to beneficiary care services rendered after the time of preparation, they may be capitalized as deferred charges and amortized. Start-up costs include allowable costs incident to the start-up period. Costs that are properly identifiable as organization costs or capitalized as construction costs must be appropriately classified as such and excluded from start-up costs.

Start-up costs are amortized over a period of 60 months, beginning from the month of first admission of a beneficiary.

Depreciation

An appropriate allowance for depreciation on buildings and equipment related directly to beneficiary care services is an allowable cost. Depreciation must be computed by the straight-line method only. The estimated useful life of fixed assets will be based on the American Hospital Association's "Estimated Useful Lives of Depreciation Hospital Assets" according to the HIM-15, Part I, Section §104.17.

Facilities must maintain adequate records to determine cost, value, and reasonable useful life of buildings and equipment. Assets must be capitalized if cost is at least $5,000 and if they have a useful life of at least two years.

For depreciation expense to be allowable, the depreciation schedule must:

- Include each asset in use with adequate description of the asset;

- Include the historical cost and accumulated depreciation;
- Include the assets' dates of acquisition;
- Indicate useful life and depreciation method;
- Reconcile to the provider's trial balance; and
- Correspond to the cost report period.

If the provider uses an accelerated depreciation method for book purposes, the provider must prepare and submit a straight-line depreciation schedule for the cost reporting period.

So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by LDH.

For example, if a fifty-year old building is used at the time the provider enters the program, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is twenty years, (seventy years from the date of acquisition) the provider may claim depreciation over the next twenty years if the asset is in use that long.

Valuation of In-Kind Contributions

In-kind contributions represent the value of non-cost contributions related to the direct care of beneficiaries provided by private organizations and individuals. In-kind contributions may consist of charges for real property and equipment and value of goods and services directly benefiting and specifically identifiable to all beneficiaries in the approved program.

Specific procedures for the facilities in placing a value on in-kind contributions from private organizations and individuals are set forth below.

Valuation of Volunteer Services

Volunteer services may be counted as a program cost only if the requirements of the HIM-15, Part I, Chapter 7 are met. In order to qualify under this chapter, volunteers must work more than 20 hours per week in various types of full-time positions that are normally occupied by paid personnel of providers not operated by or related to religious orders. Services must be related directly to beneficiary care or in administrative positions essential to the provision of that care.

Volunteers must be members of an organization of non-paid workers that has arrangements with the provider for the performance of services by volunteer workers without direct remuneration to the volunteer by either organization.

Value for volunteers cannot exceed the amounts for regular working hours (excluding overtime) of paid employees who perform similar services. If there are no similar positions within the organization, the valuation cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services, and utilization.

Normal fringe benefits can be included in the valuation, but social security taxes, workmen's compensation, State unemployment insurance and any other costs stemming from legislative requirement cannot be included.

Valuation of Donated Equipment, Buildings, and Land, or Use of Space

The value of donated property will be determined as follows:

- Equipment and buildings:

  The value of donated equipment or buildings should be based on the donor's cost less depreciation or the current market prices of similar property, whichever is less. The current market price should be established by a recognized appraisal expert. The title of the donated equipment and building must be legally in the name of the facility.

- Land or use of space:

  The value of donated land should be based on the donor's cost or the current market price of similar property. The current market prices should be established by a recognized appraisal expert. Use of space will not be considered in determining allowable cost with one exception. The exception is if the provider and the donor organization are both part of a larger organizational entity, such as units of a state or parish government, the cost related to the donated space is included in the allowable cost of the provider.

Valuation of Other Costs

Other necessary costs incurred specifically for an indirect benefit to the program on behalf of all beneficiaries may be accepted as program costs provided they are adequately supported and permissible under the approved program. Such costs must be reasonable and properly documented.

Consultants, such as pharmacy consultants, not qualifying under the provisions for valuation of volunteer services, will qualify for valuation under this section, provided the service is an integral and necessary part of an approved program.

The following requirements pertain to the facility's supporting records for in-kind contributions from private organizations and individuals:

- The extent of volunteer services must be supported by the same methods used by the facilities for its employees; and

- The basis for determining the costs for personal services, equipment, and buildings must be documented.