

STATE OF ALASKA

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DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF RATE REVIEW

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TO ALL INTERESTED PARTIES

Subject: Changes in Department of Health & Social Services
Reporting Manual

Listed below are the changes in the DHSS Medicaid Hospital and Long-Term Care Facility Reporting Manual dated September 2005, as compared to the Reporting Manual dated April 2004.

YEAR END REPORT

1. Facilities may now submit their electronic copy of the Medicare cost report on either a diskette or compact disk.
2. Instructions have been changed to match clarification of regulations requiring that the audited financial statements required to be filed with the year end report be specific to the facility and match the period reported on the Medicare cost report.
3. Instructions for Medicaid Form T-2, page 1, line 14 have been revised to reflect the change in the form. Facilities are required to separately report the number of available beds (beds set-up and ready to be used) and the number of licensed beds for each category listed.
4. Instructions for Medicaid Form SS-1A, line 33 have been clarified to aid in the reporting of health care "related" training expenses sponsored by trade organizations or associations.

Facilities are required by regulation to use the instructions and forms from the September 2005 reporting manual for all reports submitted to the Department after March 18, 2006.

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
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MEDICAID HOSPITAL AND LONG-TERM CARE FACILITY
REPORTING MANUAL

REPORTING INSTRUCTIONS AND FORMS

SEPTEMBER, 2005

Year End Report Instructions

**STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
YEAR END REPORT INSTRUCTIONS**

The following forms are a required part of the Year End Report package.

1. Uniform Medicare Cost Report as reported to the Medicare Intermediary, Form HCFA-2552 or Form HCFA-2540, as appropriate. Also include a diskette or Compact Disc (CD) containing the electronic version of the cost report (identical to the hard copy version), and the following Medicare Cost Report Supporting documentation.

a. Medicare Home Office Cost Statement, Form HCFA-287, if applicable, a copy of the finalized, most recently audited, Medicare home office cost statement audited by Medicare.

b. Medicare Provider Cost Report Reimbursement Questionnaire, Form HCFA-339, if applicable.

c. Any additional supporting schedules sent to the Intermediary with the Medicare cost report; for example, work papers supporting reclassification entries or other adjustments.

2. Audited Financial Statements.

3. Audit adjustments made by the Independent Financial Statement auditors.

4. Reconciliation of the Audited Financial Statements to the Medicare Cost Report, Worksheet A.

5. Post Audit Working Trial Balance.

6. Reconciliation of the Post Audit Working Trial Balance to the Medicare Cost Report worksheet forms: A, A-8, C and G series.

7. The following Department of Health & Social Services (DHSS) Year End Report Forms:

- a. Form YET-1.
- b. Form T-2.
- c. Form T-15.
- d. Form SS-1A.

Year End Report Instructions

- e. Form SS-1B.
- f. Form SS-1C.
- g. Form FS-3.

GENERAL INSTRUCTIONS

A. All data submitted on the year end forms is to be actual data for a facility's most recent fiscal year end. (For example: a 6/30/2005 facility would submit the actual data for the period 7/1/2004 through 6/30/2005 on its year end report due 150 days after 6/30/2005.

B. If forms and schedules listed in items 1, 4, and 6 below have not been filed with the Medicare Intermediary due to an extension granted by Medicare, all other forms and schedules still must be completed and submitted to Medicaid within the timelines set out in 7 AAC 43.679(c).

C. If Medicare has extended the time for filing the Medicare Cost Report beyond 150 days after the most recent fiscal year end, then forms and schedules listed in items 1, 4, and 6 below must be filed with Medicaid within the extension allowed by Medicare.

D. Forms, schedules, and reports not submitted within the timelines as described in paragraphs B and C will be considered not timely filed.

1. FORM - UNIFORM MEDICARE COST REPORT AS REPORTED TO THE MEDICARE INTERMEDIARY, INCLUDING A DISKETTE OR COMPACT DISC CONTAINING THE ELECTRONIC COST REPORT (IDENTICAL TO HARD COPY VERSION), FORM HCFA-2552 OR FORM HCFA-2540, AS APPROPRIATE.

Medicaid data must be completed in the cost report. If a low utilization cost report is used, the B-1 worksheet with statistics must be attached. A complete Medicare Cost Report includes:

a. Form - Medicare Home Office Cost Statement, Form HCFA-287.

b. Form - Medicare Provider Cost Report Reimbursement Questionnaire, Form HCFA-339.

Year End Report Instructions

c. Form - any additional supporting schedules sent to the Medicare Intermediary with the Medicare Cost Report; for example, work papers supporting reclassification entries or other adjustments.

2. FORM - AUDITED FINANCIAL STATEMENTS SPECIFIC TO THE FACILITY AND MATCHING THE PERIOD REPORTED ON THE MEDICARE COST REPORT.

3. FORM - INDEPENDENT AUDIT ADJUSTMENTS.

4. FORM- RECONCILIATION OF THE AUDITED FINANCIAL STATEMENTS TO THE MEDICARE COST REPORT, WORKSHEET A.

5. FORM - POST AUDIT WORKING TRIAL BALANCE.

The post audit working trial balance should include the Audit Adjustments made by the Independent Financial Statement Auditors.

6. FORM - RECONCILIATION OF THE POST AUDIT WORKING TRIAL BALANCE TO THE MEDICARE COST REPORT FORMS WORKSHEETS A, A-8, C, AND G SERIES.

Each revenue and expense account listed in the Provider's working trial balance should be annotated by the cost center number which makes up the total expenses or charges found on Worksheets A, A-8 and C. For amounts included on worksheet G-3, but not on worksheet A-8, annotate G-3 line number.

7. FORM - The DHSS Year End Report forms as follows:

a. FORM YET-1 TRANSMITTAL AND CERTIFICATION

This form must be read, understood, and signed by the chief administrative or financial officer of the health facility.

b. FORM T-2 HEALTH FACILITY GENERAL INFORMATION

This form is used to report general information and the historical utilization of the facility.

11., 12. Volume statistics (Number of Admissions, Number of and
13. Patient Days and Number of Visits) reflect the

Year End Report Instructions

most current year's operation completed by the facility.

The base year-facility column reflects the total facility's operation.

The base year-MEDICAID column reflects the Medicaid (Title XIX) utilization.

14. The number of beds available for service reflects the most current year's operation completed by the facility. The count should reflect the total number of beds available and the total number of licensed beds as of the facility's fiscal year end.

The base year-facility column reflects the total number of beds available for service and the total number of licensed beds (#available beds/#licensed beds).

The base year-Medicaid column enter data only if the beds certified for Medicaid services is different from the facility total.

15. This line should be completed by Facilities with a 6/30 year end only. Facilities with fiscal year ends of 12/31, do not complete this set of volume statistics.
16. This line should be completed by Facilities with a 6/30 year end only. Facilities with fiscal year ends of 12/31, do not complete this set of volume statistics.

c. **FORM T-15 - FACILITY BASED PHYSICIANS COMPENSATION**

General Instructions:

This form reports the financial arrangements with facility based physicians for the prior year.

Column 1, report the provider billing identification number used to obtain reimbursement for the physician's services. Each Physician must be listed on successive lines.

Column 2, signify the type of financial arrangement by choosing the number listed below which best describes the financial arrangement.

Year End Report Instructions

1. A joint or salaried arrangement is one in which the health facility bills patients for the physicians services, and includes these revenues as health facility revenues. All department expenses are paid by the health facility. The health facility remits a fee or salary to the physician which is included in health facility expense. All payments to physicians are identified on the Medicare Cost Report, Worksheet A-8-2.
2. A contracted department is an arrangement where the physician may pay any or all expenses of the department. The health facility bills patients for the departmental services and remits a fee to the physician. This fee would typically be designed to cover the expenses incurred by the physician plus his/her professional fee. Payments to the physician are recorded as Professional Fees (regardless of the expenses incurred by the physician) and reported on the Medicare Cost Report, Worksheet A-8-2.
3. A rental department is an arrangement whereby the physician bills patients for services rendered by the department and pays a rental fee for the use of departmental services. This rental is recorded as "other operating revenue" in the department and is offset against departmental expense in the reclassification process on the Medicare Cost Report.
4. An independent/separate department arrangement is an arrangement whereby the department functions are provided by an independent individual group of physician(s). Neither revenues or expense are incurred by the health facility. The health facility usually refers patients and/or specimens to the outside group, usually located on separate premises.
5. A physician clearing account arrangement is when the health facility bills patients for the physician's services, and records these billings as a liability. The subsequent payment to the physician is shown as a reduction of that liability. The hospital reflects neither revenue or expense relative to the professional services.

Year End Report Instructions

6. Other: If this description applies, please include a narrative explaining the type of financial arrangement in effect.

Column 3, list the cost center or department for which services were performed. If a Physician performed services for more than one cost center, use a separate line to report the salaries and compensation which were included in each cost center.

Column 4, list name of physician or include brief description of type work done.

Columns 5, 6, 7 and 8, list the total compensation paid by the facility for each cost center. This includes all components of physician compensation, i.e., monetary payments, fringe benefits, deferred compensation, physician professional membership fees, continuing education, malpractice and any other items of value.

d. FORM SS-1A REVENUE ANALYSIS

General Instructions:

This form reports all operating/non-operating revenues and other required reporting items for the health facility.

STEP LINE

- | | | |
|---|-----|--|
| 1 | 1-8 | Distribute the Patient Service Revenues among Inpatient--routine and ancillary, Long Term Care--routine and ancillary, Swing Bed--routine and ancillary, outpatient, and other revenues earned from patient sources (please include a descriptive narrative of the way in which the "other" patient revenues were earned). |
| 2 | 9 | Total lines 1 through 8 to equal total patient service revenues. |
| 3 | 10 | Enter the amount of Other Operating Revenues that have been reclassified or offset against departmental expenses. (Include a schedule which details the Working Trial Balance (WTB) accounts which were |

Year End Report Instructions

accumulated to total to the Other Operating Revenues amount if multiple WTB accounts were combined).

- 4 11 Enter the amount of federal, state, or regional-local taxes that are intended to or will be used to fund current operations.
- 5 12 Enter the amount of grants intended to be or which were used for current operations.
- 6 13 Enter the amount of revenue sharing the facility receives.
- 7 14 Enter all other revenue offsets intended to be used or that were used to offset operations.
- 8 15 Total lines 10-14.
- 9 16-20 Enter non-operating revenues under the appropriate heading.
- 10 21 Enter the amount of Other Non-Operating Revenue (if multiple WTB accounts were combined, include a schedule which details the WTB accounts which were accumulated to total to the amount reported under Other Non-Operating Revenues).
- 11 22 Total lines 15-21.
- 12 23-26 Enter Non-Operating expense in the lines provided.
- 13 27 Enter the amount of Other Non-Operating Expense (if multiple WTB accounts were combined, please include a schedule which details the WTB accounts which were accumulated to total to the amount reported under Other Non-Operating Expense).
- 14 28 Total lines 23-27.
- 15 29 Subtract line 28 from line 22 and enter the amount on line 29.
- 16 31 Enter amount of advocacy expenses. These include costs associated with advocacy activities, lobbying activities, and special assessments to fund the

Year End Report Instructions

preparation of advocacy and position papers. Include a schedule of costs by WTB account number and amounts reported.

- 17 32 Enter amount of membership dues, meeting fees, conference fees, and trade organization and association fees. Include a schedule of costs by WTB account number and amounts reported.
- 18 33 Enter amount of health care related training expenses sponsored by trade organizations or associations. Include a schedule of costs by WTB account number and amounts reported
- 19 34 Enter amount of plaintiff/appellant litigation expenses. Please schedule and reconcile amounts by WTB account number, amount, case name, and stage of litigation (e.g. "on going" or "resolved," etc.). Attach a copy of the final order showing that facility was prevailing party. Note that expenses incurred because of litigation not originally initiated by the facility are not subject to this requirement or 7 AAC 43.686(b)(15).

e. FORM SS-1B HISTORICAL SUMMARY

- Column 1 Total facility revenue, acute and long term care, is taken from the facility's general ledger (and includes charity care revenues).
-
- Column 2 Total long term care facility revenue is taken from the facility's general ledger (and includes charity care revenues).
- Column 3 Revenue billed to Medicaid for inpatient hospital services is recorded here. The facility should use the Medicaid logs or the general ledger.
- Column 4 Revenues billed to Medicaid for outpatient hospital services is recorded here. The facility should use the Medicaid log or the general ledger.
- Column 5 Revenue billed to Medicaid for long term care services is recorded here. Ancillary charges for services provided to long term care patients is to be recorded

Year End Report Instructions

in this column also. The facility should use the Medicaid logs or the general ledger.

Column 6 Revenue billed to Medicaid for swing bed services is recorded here. Ancillary charges for swing bed ancillary services are also recorded in this column. The facility should use the Medicaid logs or the general ledger.

f. FORM SS-1C FACILITY BASED PHYSICIAN'S REVENUE

This form needs to be completed to disclose any Physician charges which were included in charge information reported on DHSS Worksheet SS-1B. If physician charges were not included in charge information reported on DHSS Worksheet SS-1B, indicate on the form but do not complete form.

Column 1, indicate total facility based physician, acute and long term care, revenues by cost center.

Column 2, indicate total long term care facility based physician revenues by cost center.

Columns 3, 4, 5 and 6, report facility based physician revenue for the Medicaid Program, by patient classification (inpatient, outpatient, long term care and swing bed) and by cost center.

g. FORM FS-3 INCOME STATEMENT

General Instructions:

This form records the patient services revenue, other revenue, expenses by natural classification and non-operating revenue or expense.

DEPARTMENT OF HEALTH & SOCIAL SERVICES TRANSMITTAL AND CERTIFICATION

NAME OF FACILITY _____

ADDRESS _____

FISCAL YEAR END _____

CERTIFICATION OF OFFICER OF HEALTH FACILITY

I hereby certify that I have examined the accompanying Year End Reporting Forms. To the best of my knowledge and belief, the data submitted are true, and correct statements prepared from the books and records of the Health Facility in accordance with the instructions provided in the Department of Health & Social Services Reporting Manual, except as conspicuously noted.

SIGNATURES

CHIEF EXECUTIVE OFFICER	OR	CHIEF FINANCIAL OFFICER
_____		_____
DATE _____		DATE _____

DEPARTMENT OF HEALTH & SOCIAL SERVICES HEALTH FACILITY GENERAL INFORMATION

1. Fiscal Year End: _____
2. Facility: _____
3. Address: _____
4. City and Zip: _____
5. Telephone: _____
6. Chief Executive Officer: _____
7. Chief Financial Officer: _____
8. Chairman of the Board: _____

9. Type of Organization: (check one)

Non-Profit	State	Other
Profit	Church	

10. Has the controlling organization, through a contract, placed responsibility for administration of the facility with another organization?

Yes	No
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VOLUME STATISTICS

11. **NUMBER OF ADMISSIONS**

	Base Year-Facility	Base Year-Medicaid
a. Adults and Peds		
b. Swing Beds		
c. Hospice		
d. Intensive Care		
e. Other Special Care		
f. Nursery		
g. Subprovider: Psychiatric/Substance Abuse		
h. Skilled Nursing/Intermediate		
i. ICF/MR		
j. Residential		
k. Other (Specify)		
l. Other (Specify)		
m. Total		

12. **NUMBER OF PATIENT DAYS**

a. Adults and Peds		
b. Swing Beds		
c. Hospice		
d. Intensive Care		
e. Other Special Care		
f. Nursery		
g. Subprovider: Psychiatric/Substance Abuse		
h. Skilled Nursing/Intermediate		
i. ICF/MR		
j. Residential		
k. Other (Specify)		
l. Other (Specify)		
m. Total		

13. **NUMBER OF VISITS**

a. Psychiatry Day Care		
b. Emergency		
c. Short Stay		
d. Clinics		
e. Home Care Services		
f. Other		
g. Total		

14. **NUMBER OF BEDS AVAILABLE/LICENSED FOR SERVICE**

	Available	Licensed
a. Adults and Peds		
b. Swing Beds		
c. Hospice		
d. Intensive Care		
e. Other Special Care		
f. Nursery		
g. Subprovider: Psychiatric/Substance Abuse		
h. Skilled Nursing/Intermediate		
i. ICF/MR		
j. Residential		
k. Other (Specify)		
l. Other (Specify)		
m. Total Available		
n. Total Licensed		

DEPARTMENT OF HEALTH & SOCIAL SERVICES

HEALTH FACILITY GENERAL INFORMATION

This form only needs to be completed by Facilities with a 06/30 year end.

FACILITY NAME:

FYE:

15.

SWING BEDS	07/01 through 12/31	07/01 through 12/31
	Base Year-Facility	Base Year-Medicaid
Admissions		
Patient Days		

16.

SWING BEDS	01/01 through 06/30	01/01 through 06/30
	Prior Year-Facility	Prior Year-Medicaid
Admissions		
Patient Days		

**DEPARTMENT OF HEALTH & SOCIAL SERVICES
FACILITY BASED PHYSICIANS COMPENSATION**

FORM T-15

FACILITY NAME:

FYE:

LINE NO.	PROVIDER BILLING I.D. NUMBER	FINANCIAL ARRANGEMENT	COST CENTER	DESCRIPTION	SALARY	FRINGE BENEFITS	OTHER PAYMENTS & BENEFITS	TOTAL COMPENSATION
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1								
2								
3								
4								
5								
6								
7								
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**DEPARTMENT OF HEALTH & SOCIAL SERVICES
REVENUE ANALYSIS**

FACILITY NAME:

FYE:

Line No.		Base Year	Explanation References
	Patient Services Revenue	(1)	(2)
1	Inpatient - Acute - Routine Services		
2	Inpatient - Acute - Ancillary Services		
3	Long Term Care - Routine Services		
4	Long Term Care - Ancillary Services		
5	Swing Bed - Routine		
6	Swing Bed - Ancillary		
7	Outpatient		
8	Other (Specify)		
9	Total Patient Service Revenue		
	Other Sources of Revenue		
10	Other Operating Revenues		
11	Taxes for Interest or Operations		
12	Grants - Restricted to Operations		
13	Revenue Sharing		
14	Other (Specify)		
15	Total Other Sources of Revenue		
	Non-Operating Revenue & Expenses, Other Reporting Items		
	Non-Operating Revenue		
16	Gain/Loss on Sale of Assets		
17	Income from Board Designated Investments		
18	Retail & Rental Revenue		
19	Unrestricted Donations		
20	Unrestricted Grants-Including Revenue Sharing		
21	Other Non-Operating Revenue		
22	Total Non-Operating Revenue		
	Non-Operating Expenses		
23	Retail & Rental Expense		
24	Retail Other Non-Operating Expense		
25	Extraordinary Items		
26	Provision for Income Tax		
27	Other Non-Operating Expense		
28	Total Non-Operating Expense		
29	Net Non-Operating Revenue (Expense)		
	Other Reporting Items		
30	Advocacy Expenses		
31	Advocacy, Lobbying, Special Assessments		
32	Dues, Meetings, Conferences Fees, Memberships (list at 100%)		
33	Direct Health Care Training Expenses		
34	Plaintiff/Appellant Litigation Expenses		

**DEPARTMENT OF HEALTH & SOCIAL SERVICES
HISTORICAL SUMMARY**

FACILITY NAME:

FYE:

Line No.		Total Acute & LTC Revenue	Total LTC Revenue	Medicaid Revenue			
				Inpatient	Outpatient	Long Term Care	Swing Bed
	Daily Hospital Services	(1)	(2)	(3)	(4)	(5)	(6)
1	Adults and Peds						
2	Swing Beds						
3	Hospice						
4	Intensive Care						
5	Other Special Care						
6	Nursery						
7	Subprovider: Psychiatric/Substance						
8	Skilled Nursing/Intermediate						
9	ICF/MR						
10	Residential						
11	Other (Specify)						
12	Other (Specify)						
13	Total Daily Hospital Services						
	Ancillary, Outpatient & Other Svcs						
14	Operating Room						
15	Recovery Room						
16	Delivery & Labor						
17	Anesthesiology						
18	Radiology-Diagnostic						
19	Radiology-Therapeutic						
20	Ultrasound						
20	Cat Scan						
21	MRI						
22							
23	Laboratory						
24	Blood, Storing, Processing						
25	Intravenous Therapy						
26	Respiratory Therapy						
27	Physical Therapy						
28	Occupational Therapy						
29	Speech Pathology						
30	Electrocardiology						
31	Electroencephalography						
32	Med Supplies Chrg to Patients						
33	Drugs Charged to Patients						
34	Renal Dialysis						
35	Other Ancillary (Specify)						
36							
37	Clinic						
38	Emergency						
39	Observation Beds						
40	Other Outpatient (Specify)						
41	Ambulance						
42	Home Health Services						
43	Other Services (Specify)						
	Total Ancillary, Outpt, Other Svcs						
44	Total Services						

DEPARTMENT OF HEALTH & SOCIAL SERVICES FACILITY BASED PHYSICIAN'S REVENUE

Use this form to report any Physician Revenue Amounts which were included on Department of Health & Social Services Form SS-1B.

FACILITY NAME:

FYE:

Line No.		Total Acute & LTC Revenue (1)	Total LTC Revenue (2)	Medicaid Revenue			
				Inpatient (3)	Outpatient (4)	Long Term Care (5)	Swing Bed (6)
	Daily Hospital Services						
1	Adults and Peds						
2	Swing Beds						
3	Hospice						
4	Intensive Care						
5	Other Special Care						
6	Nursery						
7	Subprovider:Psychiatric/Substance						
8	Skilled Nursing/Intermediate						
9	ICF/MR						
10	Residential						
11	Other (Specify)						
12	Other (Specify)						
13	Total Daily Hospital Services						
	Ancillary, Outpatient & Other Svcs						
14	Operating Room						
15	Recovery Room						
16	Delivery & Labor						
17	Anesthesiology						
18	Radiology-Diagnostic						
19	Radiology-Therapeutic						
20	Ultrasound						
20	Cat Scan						
21	MRI						
22							
23	Laboratory						
24	Blood, Storing, Processing						
25	Intravenous Therapy						
26	Respiratory Therapy						
27	Physical Therapy						
28	Occupational Therapy						
29	Speech Pathology						
30	Electrocardiology						
31	Electroencephalography						
32	Med Supplies Chrg to Patients						
33	Drugs Charged to Patients						
34	Renal Dialysis						
35	Other Ancillary (Specify)						
36							
37	Clinic						
38	Emergency						
39	Observation Beds						
40	Other Outpatient (Specify)						
41	Ambulance						
42	Home Health Services						
43	Other Services (Specify)						
	Total Ancillary, Outpt, Other Svcs						
44	Total Services						

**DEPARTMENT OF HEALTH & SOCIAL SERVICES
INCOME STATEMENT**

FACILITY NAME:

FYE:

Line No.		BASE YEAR
	REVENUES	
	PATIENT SERVICE REVENUES	
1	Inpatient Revenues	
2	Outpatient Revenues	
3	Long Term Care Revenues	
4	Swing Bed Revenues	
5	Other Patient Revenues (Specify)	
6	Total Patient Service Revenues	
	DEDUCTIONS FROM REVENUE	
7	Bad Debts	
8	Charity Care	
9	Contractual Adjustments	
10	Other	
11	Total Deductions from Revenue	
12	NET PATIENT SERVICES REVENUE	
13	OTHER SOURCES OF REVENUE	
	OPERATING EXPENSES	
14	Salaries and Wages	
15	Employee Benefits	
16	Professional Fees	
17	Supplies	
18	Purchased Services - Utilities	
19	Purchased Services - Other	
20	Depreciation/Rental/Lease	
21	Insurance	
22	Interest Expense	
23	Taxes	
24	Other Direct Expense	
25	Total Operating Expenses	
26	NET INCOME (LOSS) BEFORE TAX	
27	Provision for Income Tax	
28	NET INCOME (LOSS)	

Budget Forms Instructions

**STATE OF ALASKA
DEPARTMENT OF HEALTH & SOCIAL SERVICES
BUDGET FORMS INSTRUCTIONS**

The following Department of Health & Social Services (DHSS) forms need to be completed only by Facilities that have received a Certificate of Need for at least \$5 Million, for the Budget Form submittal package. If your facility does not have any capital projects which required a Certificate of Need of at least \$5 Million, your facility is not required to submit the following Budget forms:

1. Form T-1 Transmittal and Certification.
2. Form SS-3 Other Direct Expenses.
3. Form SS-5 Depreciation on Assets Requiring A Certificate Of Need.

GENERAL INSTRUCTIONS

Budget forms are only required from facilities with an approved Certificate of Need of at least \$5 Million for capital projects. Only capital outlays which have been approved for a CON of at least \$5 Million are subject to the budget process. Historical data comes from the most recent year.

The facilities must provide a reconciliation to the audited prior year financial statements identifying the assets shown on the financial statements and the assets upon which depreciation is claimed.

1. FORM T-1 TRANSMITTAL AND CERTIFICATION

This form must be read, understood, and signed by the Chief Executive Officer and the Chairman of the Governing Board of the health facility.

2. FORM SS-3 OTHER DIRECT EXPENSES

General Instructions:

This form is to be used for recording insurance, interest, and rental and lease costs. The data for Column 1, year 1, is estimated. The data for Column 2, year 2, is projected data. The

Budget Forms Instructions

data for Column 3, the prospective payment year, is projected data.

The line instructions are as follows:

Line

- 1 Enter the Property Insurance cost amounts.
- 2 Enter other insurance paid not specially shown as a line item. Describe the expense in the space provided.
- 3 Total lines 1-2.
- 4 Enter the amount of interest paid on mortgage.
- 5 Enter the amount of interest paid on outstanding bonds to bondholders.
- 6 Enter the amount of interest paid on equipment.
- 7 Enter other interest paid for items not specifically shown as a line item. Describe the type of interest expense in the space provided.
- 8 Add lines 4-7.
- 9 Enter rental or lease amounts paid for buildings used to perform Health Care Services.
- 10 Enter rental or lease amounts paid for Housing of Staff.
- 11 Enter rental or lease amounts paid for equipment.
- 12 Enter total of lines 9-11.

3. FORM SS-5 DEPRECIATION ON ASSETS REQUIRING A CERTIFICATE OF NEED

General Instructions:

This form accumulates the assets for land, land improvements, building, fixed equipment, movable equipment, leasehold improvements, and construction in progress. It also displays the accumulated depreciation and the depreciation expense (assigned

Budget Forms Instructions

and unassigned). The data for lines 1 - 10, year 1, is estimated. The data for lines 11 - 24, the year 2, is projected data. The data for lines 28 - 37, the prospective payment year, is projected data.

STEP LINE

- 1 1-9 Enter the estimated amounts for year 1 from the general ledger by classification. Make sure to appropriately total the ending balance columns (columns 4, 8 and 10). The amount of depreciation expense directly expended to cost centers should be included in column 7. The amount allocated to cost centers should be included in column 6. The sum of columns 6 and 7 is equal to the total provision for depreciation (column 8).
- 2 10 Total columns 1-8.
- 3 13-21 Enter the year 2 projected amounts by general ledger classification. Make sure to appropriately total the ending balance columns (columns 4 and 8). The amount of depreciation expense directly expended to cost centers should be included in column 7. The amount allocated to cost centers should be included in column 6. The sum of columns 6 and 7 is equal to the total provision for depreciation (column 8).
- 4 22 Total columns 1-8.
- 5 25-33 Enter the projected prospective payment year amounts for the prospective payment year by general ledger classification. Make sure to appropriately total the ending balance columns (columns 4 and 8). The amount of depreciation expense directly expended to cost centers should be included in column 7. The amount allocated to cost centers should be included in column 6. The sum of columns 6 and 7 is equal to the total provision for depreciation (column 8).
- 6 34 Total columns 1-8.

Provide supporting schedules for columns 2 and 3, lines 1-9, 15-23 and lines 28-36, which list the assets which comprise the additions and retirements in each major category for Year 1 estimated and Year 2 and Prospective Payment Year

Budget Forms Instructions

projected. Indicate which column 2 assets have been purchased to date and which are projected to be purchased by years end. For each asset give an asset description, purchase or anticipated purchase expense and date, asset life, anticipated depreciation and department location. For single or group purchase which required a Certificate of Need of at least \$5 Million under AS 18.07.031 list the date of the approval.

DEPARTMENT OF HEALTH & SOCIAL SERVICES

TRANSMITTAL AND CERTIFICATION

NAME OF FACILITY _____

ADDRESS _____

CONTACT PERSON _____

CONTACT PHONE _____

FISCAL YEAR END _____

TYPE OF SUBMITTAL _____

PROPOSED EFFECTIVE DATE _____

CERTIFICATION OF OFFICER OF HEALTH FACILITY

I hereby certify that I have examined the accompanying Budget Submittal, the proposed prospective payment rates, and proposed effective date for the prospective payment year ending / / . To the best of my knowledge and belief, the data submitted are true, and correct statements prepared from the books and records of the Health Facility in accordance with the instructions provided in the Department of Health & Social Services Reporting Manual, except as conspicuously noted, and represent the financial requirements, prospective payment rates, and effective date necessary to meet the needs of the Health Facility for the prospective payment period.

SIGNATURES

CHIEF EXECUTIVE OFFICER

CHAIRMAN OF GOVERNING BOARD

DATE _____

DATE _____

**DEPARTMENT OF HEALTH & SOCIAL SERVICES
DEPRECIATION ON ASSETS REQUIRING A CERTIFICATE OF NEED**

FACILITY NAME:

FYE:

Line No.		Fixed Assets				Accumulated Depreciation		Total Provision (5+6)= (7)
		Beginning Balance (1)	Additions (2)	Retirement (3)	Ending Balance (4)	Unassigned Expense (5)	Depreciation (6)	
	Year One							
1	Land							
2	Land Improvements							
3	Building							
4	Fixed Eqpt. - Bldg. Svc.							
5	Fixed Eqpt. - Other							
6	Eqpt. - Major Moveable							
7	Eqpt. - Minor							
8	Leasehold - Improvement							
9	Construction In Progress							
10	Prior Year Total							
11								
12	Year Two							
13	Land							
14	Land Improvements							
15	Building							
16	Fixed eqpt. - Bldg. Svc.							
17	Fixed Eqpt. - Other							
18	Eqpt. - Major Moveable							
19	Eqpt. - Minor							
20	Leasehold - Improvement							
21	Construction in Progress							
22	Current Year Total							
23								
24	Prospective Payment Year							
25	Land							
26	Land Improvements							
27	Building							
28	Fixed Eqpt. - Bldg. Svc.							
29	Fixed Eqpt. - Other							
30	Eqpt. - Major Moveable							
31	Eqpt. Minor							
32	Leasehold - Improvments							
33	Construction in Progress							
34	Prospective Payment Year Total							
35								
36	Explanation							
37								