Cost Survey 2016 Instructions

Alaska Personal Care and Home & Community Based Waiver Services

General Information

This cost survey must be used to report costs in accordance with 7 AAC 145.531 - 537. The survey document is designed for use by both simple and complex providers of Medicaid Personal Care and Home and Community Based (HCB) Services. It has been constructed to be as simple as possible while providing the Department with the minimum amount of information necessary to calculate reimbursement rates, monitor the provider community's financial health, and provide a basis to evaluate compliance with Department regulations.

For these purposes all PCA and HCB services being provided under the same Employer Identification Number (EIN) are considered one consolidated provider and must be reported on one Cost Survey.

A reporting provider must include all of its PCA and HCB operations on one survey document. Along with the PCA and HCB operations of a provider, the cost survey and Audited Financial Statements must include other operations or functions which;

1) Are managed or supervised by staff who's salaries or expenses are reported on the cost survey; or
2) Share space or staff.

Examples of when a single (consolidated) Cost Survey is required:

1) Primary business is PCA/HCB service provision but the owner or Chief Executive Officer/General Manager of the provider also manage or exercise operational control other operations. Other operations could be a different healthcare business such as a Home Health Agency or a non-healthcare business such as a laundry service.
2) Individual or corporation has four Medicaid provider numbers. Three are HCB provider numbers and one is a non-PCA/HCB Medicaid provider number. However, the owner has only one EIN.

A large provider with a significant amount of non PCA/HCB operations may choose to separately account for its PCA/HCB operations and obtain a separate AFS. In this case a provider may allocate some costs from the larger institution to the PCA/HCB operations. The provider must identify the amount of the cost included from the home office on the PCA/HCB cost survey and AFS and separately provide supporting documentation. The supporting documentation must detail services provided to the PCA/HCB portion, cost elements, and the allocation method used to attribute the cost to the PCA/HCB operations. A large hospital complex is a good example of this situation.

Financial and other information necessary for completion of the Cost Survey must be provided from the provider's books and records. When additional information is necessary it will be requested and the provider will separately submit. Providers should

review the requirements of 7 AAC 145.531 through 7 AAC 145.537 prior to completion of the survey.

The Cost Survey utilizes natural expense classifications and common terminology in the industry and is self-guiding to a large extent. The forms reflect the accounting requirements of 7 AAC 145.531 and also provide some direction for completion of the survey. The provider should consult these instructions if the survey forms are not sufficiently clear.

Survey document worksheets have been designed to capture adequate data from both large and complex institutions as well as small providers. Smaller providers may utilize only a small amount of the reporting space available on these forms. **Data entry areas are shaded in green.** Please note that the shaded areas will not fax well.

An Annual Cost Report includes:

1) Completed *Cost Survey, 2016* document with all worksheets:
    a. Certification Worksheet, signed by the chief executive officer
    b. Expense Worksheet: Required only when a full cost report called, at least every four years.
    c. Revenue and Statistics Worksheet
    d. Home Office Worksheet: Required only when a full cost report called, at least every four years.
    e. Related Party Worksheet: Required only when a full cost report called, at least every four years.
    f. Buildings Worksheet: Required only when a full cost report called, at least every four years.
2) Audited Financial Statements (AFS);
3) Post audit working trial balance; and
4) Reconciliation of the post audit working trial balance to the Expense Worksheet of the Cost Survey.
5) Worksheets, documentation, or other support necessary to explain variances between amounts reported on the cost survey and the requirements found in 7 AAC 145.531 through 7 AAC 145.537 must be included.

Certification Worksheet

Provider Business Name, Provider Name: Provide the name of the Business and the provider's name in the green shaded boxes.

Provider Administrative Information: Provide the business' contact information in the green shaded box. This information includes: the administrative (business) address, phone number, a contact email address, website address, Taxpayer ID (Employer Identification Number - EIN and Medicaid provider ID(s). Some providers will not use all of the lines; however the additional information ensures proper provider identification and contacts.

Report Period: Indicate the provider's fiscal year end date of the year being cost surveyed (Month, day, and year).

Certification by Chief Executive Officer: After reviewing the information in the completed cost survey the Chief Executive Officer must certify by signing and dating.

Expense Worksheet

In this worksheet provider expenses are reported. All expenses of the consolidated business are reported. Expenses are reported under four sections:

1) General Service Costs
2) Direct Care Costs – Waiver Services
3) Direct Care Costs – Other Waiver Services: Care Coordination, PCA, and Assisted Living
4) Other Healthcare and Non-Healthcare Costs

In the right hand column of the worksheet enter the amount of the expense related to the functional area and expense classification. The total reported costs must tie to the Audited Financial Statements (AFS). If the provider must include or exclude expenses in order to comply with the regulatory requirements, support must be submitted to explain the difference.

General Service Costs

Lines 1 through 4: Report the costs of administering the provider's operations on lines 1 through 4. These costs are allowable costs that apply to the general operations of the business or benefit the organization as a whole. These costs have been incurred for the overall general, executive, and administration of the organization and do not relate solely to any particular service or operation of the provider. They cannot be readily identified with the provision of Waiver Services. Examples of general service expenses include but are not limited to:

- Accounting staff wages and benefits
- Building rent
- Consulting expenses
- Corporate management wages and benefits (such as for the chief executive officer and support staff)
- Depreciation on office equipment
- Home Office Costs or management fees
- Human Resources staff wages and benefits
- Insurance
- IT staff wages and benefits
- Legal staff wages and benefits
- Office supplies
- Outside audit fees
- Subscriptions
- Utilities of administrative space

Lines 5 - 10: Building(s) and Maintenance. These costs include depreciation, rent, lease, maintenance, and repair. The provider may choose to report **all** of the providers

Building and Maintenance costs on lines 8, 9, and 10 **or** it may choose to separately track and report these costs by function or cost center identified on the worksheet (direct assignment). A blending of reporting methods is not allowable.

> Example: An organization with $300,000 of expense in buildings and maintenance for the provider's operations may choose to report the entire amount on lines 8, 9 and 10 **or** it may choose to track and report the $300,000 by each area of usage. General Service Costs $60,000 (lines 5-7); Group Home $150,000 (line 44); Respite- Per Diem $50,000 (line 80); and Other- Healthcare $40,000 (line 116).
>
> **NOTE:** Costs from lines 1 through 10 will be allocated (distributed) to other cost areas in order to determine the complete cost of each service by the Department of Health and Social Services.

Lines 11 through 20: Non-Covered costs. Report on these lines costs that are not covered by the PCA and Home and Community Based programs.

1) Items listed in 7 AAC 145.533 are reported on these lines. Costs are **allowable costs** if they are **reasonable**, **necessary**, and **related to the service** provided.

   Note: Please review this list before completing the cost survey. Most common examples include gifts, donations, fund raising, and entertainment. Examples include but are not limited to**:** Birthday party décor, cakes, and gifts are a non-covered cost.

2) All of the costs related to the provision of grant funded services should be reported on line 17.

3) Line 20 "All Other" will be used to report all costs that do not meet the reimbursable requirements of 7 AAC 145.533 and not individually listed in lines 11-19, except for those costs that are reported in the "Other" sections on lines 113-120 and those costs that are reported in the “Care Coordination” or “Residential Supported Living” sections on lines 97-112.

Direct Care Costs – Waiver Services and PCA

Direct care costs are those which may be identified by individual Waiver Service in the sense that, if the Medicaid Service did not exist, the expense would not be incurred. Direct care costs can be identified specifically with a particular service activity. These include the expense of staff that provides the service and any related supplies.

Direct care costs reported here include the expenses for providing the service to both Medicaid and Non-Medicaid recipients. If an expense applies to two service areas or more the provider may allocate (distribute) the cost to each service area based upon its records supporting usage.

> Example: A provider purchases food for $100 and makes 100 meals. The provider does not keep separate expense records for the two services. 75 of

those meals are congregate and 25 are home delivered. A provider may allocate $75 (3/4 of the total expense) to congregate meals and $25 (1/4 of the total expense) to delivered.

Wages

Wages includes compensation made to employees or contractors for service provided.

Fringe Benefits

Fringe benefits include both mandatory and discretionary fringe benefits. Mandatory benefits include but are not limited to: Social Security withholdings, Medicare withholdings, unemployment insurance premium payment, and worker's compensation. Discretionary benefits include but are not limited to life insurance, pensions, vacation, holidays, and sick leave. Benefits would also include health insurance premiums as well as living space provided to direct care staff in residential settings in which the direct care staff does not pay rent or pays less than fair market value for rent.

Program Support

Program support costs are expenses that are neither direct care nor administrative. These activities are essential to the direct service occurring and are program specific. Program support costs can benefit more than one program and can be allocated to the benefiting programs using a reasonable and equitable basis. Examples of program support cans include but are not limited to salary and benefits for supervisors of direct service workers, direct care worker training, vehicle costs for direct service workers and their supervisors, background checks, program supplies, furnishings used for the program space (if applicable).

Building/Maintenance

Building and Maintenance expenses include but are not limited to rent, mortgage interest payments, property insurance, depreciation, utilities and repairs.

Lines 21 through 88: These lines are used to report the expenses that are directly related to the provision of Home and Community Based Waiver services. Expenses must be reported by the appropriate service type.

Example: The direct care costs associated with Group Home Habilitation (T2016, T2016 TG) must be reported on lines 41 through 44.

Note: Line 44 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Personal Care Assistant (PCA) Direct Care Cost

Lines 89 through 92: These lines are used to report the expenses that are directly related to the provision of Personal Care Assistant services.

Note: Line 92 (Buildings and Maintenance) should only be used if the provider

is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Care Coordination Direct Care Cost

Lines 93 through 96: These lines are used to report the expenses that are directly related to the provision of Care Coordination services.

Note: Line 96 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Residential Supported Living Direct Care Cost

Lines 97 through 108: These lines are used to report the expenses that are directly related to the provision of Residential Supported Living.

Note: Lines 100, 104, and 108 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Other — Healthcare (non-PCA/Waiver)

Lines 109 through 112: These lines are used to report direct expenses of non-PCA/Waiver healthcare services. Any costs associated to Waiver clients and related to SME, Private Duty Nurse, or Environmental Modifications should also be reported here.

Note: Line 112 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Example - Provider may also provide Physical Therapy, Home Health, Private Duty Nursing, SME, or other healthcare service that is not subject to the requirements of 7 AAC 145.531 through 7 AAC 145.537. General Service costs for these centers are reported in lines 1 through 7.

Other — Non-Healthcare

Lines 113 through 116: These lines are used to report direct expenses of all other expenses. These are related to other operations of the provider that were not reported above. These are non-healthcare and not subject to the requirements of 7 AAC 145.531 through 7 AAC 145.537. General Service costs for these centers are reported in lines 1 through 7. Only direct expenses are reported here.

Note: Line 116 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 8, 9, and 10.

Total expenses must tie to the provider's Audited Financial Statements and Working Trial Balance. If expenses do not agree between the forms, documentation must be provided to explain/support the differences. Each expense account should have a corresponding revenue account.

Revenue and Statistics Worksheet

PART I: This section of the worksheet is used to report revenue (charges) information. All of the consolidated provider's revenues (charges) earned in the survey report year must be reported here. The total reported revenue must tie to the Audited Financial Statements (AFS) and Working Trial Balance. If reported revenue totals do not agree between the forms, documentation must be provided to explain/support the differences. Each revenue account should have a corresponding expense account.

Revenues and units of service must be reported by service category. Both total and Medicaid units of service must be reported. Procedure code categories are provided. Use of a Medicaid procedure code does not indicate that only Medicaid revenue received from that procedure code is reported. Services similar to Medicaid services are included in the total. For example, if a provider receives $50,000 in revenue from Medicaid, and $150,000 in revenue from other payers, $50,000 is reported in the Waiver Medicaid column and $150,000 is reported in the All Other Revenue column. Units of service and revenues must be reported before any adjustments (bad debt, discounts, other).

Column 1: Report revenue received for Medicaid Home and Community Based Waiver (HCBW) and PCA services by listed procedure code.
Column 2: Report revenue received for services similar to the procedure code listed. This may include private self-pay clients, General Relief clients, Veteran's Administration, Non-Waiver Medicaid (such as Taxi), or other type of service payment.
Column 3: Automatic sum of the two prior columns.
Column 4: Report units of service paid for Medicaid HCBW and PCA services by listed procedure code.
Column 5: Report units of service paid for services similar to the procedure code listed. This may include private self-pay clients, General Relief clients, VA, or other type of service payment.
Column 6: Automatic sum of the two prior columns.

Revenues generated which are not related to services similar to HCBW services, Care Coordination, PCA services, or Assisted Living must be reported in the "Other Revenue" section.

Examples include but are not limited to: Other health care (prescription, SME) and non-healthcare related services (rentals, grant income, donations, fund raisers, interest, vending machines, laundry and on site store.)

PART II: This section of the worksheet is used to report the staffing ratio for services that include group services. This information will be used to help inform the special calculations.

Column 1: Report the average number of individuals in a group for each

service.

PART III: This section of the worksheet is used to report the number of hours paid and compensation.

Column 1: Report the number of paid hours by position type listed.

Column 2: By each position type report the amount of compensation paid. This is the amount actually paid to individuals. Amounts not paid to individuals such as insurance benefits are not reported here.

Related Party Worksheet

On this worksheet the consolidated provider must report amounts of expenditures related to transactions with related parties if they exceeded $5,000. If more than $5,000 of expenses is related party expense then all of the related party expenses contained within the Expense Worksheet must be reported.

For these cost survey purposes- Related to the provider means that the provider to a significant extent is associated or affiliated with or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. A related party is where the parties are related by common ownership or control. The existence of an immediate family relationship will create the presumption of relatedness through control or attribution of ownership or equity interests. Control exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

Examples of a reportable transaction include:

- Payments to the provider's full or part owners (individual or incorporated) for:
  - Salary,
  - Rent/lease
  - Contract services
  - Supplies
- Payments to relatives of the providers full or part owners.
  Example: Owner / provider hires nephew to mow lawns and shovel snow. If the reported expense is greater than $5,000, then it must be reported here.
- Purchase of equipment, supplies, contract services, or other item for the related party when the benefit is intended for the related party and not the operations of the providers.
- Purchase of equipment, supplies, contract services, or other item for relatives of the related party when the benefit is intended for the relative of the related party and not the provider's operations.

For each related party transaction show:

- Expense Worksheet line number that contains the expense,
- Amount of the expense,
- Name of the person or organization paid,
- Percent of related ownership;
- Hours worked, and

- Symbol which best describes the relationship between the parties.

Buildings Worksheet

This spreadsheet is used to identify each building owned, rented, or leased by the consolidated provider. All of the provider's Medicaid provider/billing numbers must be identified on this worksheet. A location may need to be repeated two or more times in order to show the business location of each Medicaid provider/bill number owned by the provider. Also, a Medicaid provider/billing number may need to be repeated to show activities of the building.

Column 1- Physical Address: Each building owned, rented, or leased by the provider must be reported in this column. Physical address must include street address and the town/city located.

Column 2- Medicaid/Provider Number: All Medicaid provider numbers of the provider must be reported in this column. A building location may need to be repeated two or more times in order to show the business location of each Medicaid provider/billing number of the provider. Also, a Medicaid provider/billing number may need to be repeated to show activities of the building if more than one building is used for services billed under the Medicaid provider/billing number.

If a provider number has no specific location the location of the general administration building or central operation building should be used.

Column 3 - Certified (licensed) beds: Report the number of certified beds of the location if appropriate. If certified status does not apply report licensed beds. If there is no bed capacity leave blank or mark N/A in the appropriate box. If the building is not used for PCA or Waiver services leave blank or mark N/A.

Column 4 – Building Use Code(s): For each location identify the use of the building by the appropriate use code. Use codes are:

1) A = General (Administration) area
2) B = PCA or Waiver Service area
3) C =Non-Waiver Service or other operations area

A building may have only one appropriate use code or it may have two or three.

Example of non-PCA/Waiver activity-space rented to non-recipient; area where other health care services (non-Waiver/PCA) are provided; unused areas; living space for individuals not providing PCA/Waiver services care; etc.

Home Office Worksheet

For Medicare and/or Medicaid purposes, a chain organization consists of a group of two or more health care facilities or at least one health care facility and any other business or entity owned, leased, or, through any other device, controlled by one organization.

Chain organizations include, but are not limited to, chains operated by proprietary organizations and chains operated by various religious, charitable and governmental organizations. A chain organization may also include business organizations engaged in other activities not directed related to health care.

Home offices of chain organization vary greatly in size, number of locations, staff, mode of operations, and service furnished to the facilities in the chain. Home offices usually furnish central management and administrative services, e.g., centralized accounting, purchasing, personnel services, management direction and control, and other services.

Often the home office of a chain organization charges a management fee to the providers in the chain for services the home office furnishes. Management fees charges between related organizations are not allowable costs except as provided in CMS Pub. 15-I, Chapter 10. Such fees must be deleted from the provider's cost report. However, when management fees between related organizations are disallowed, the home office's reasonable costs for providing the services related to patient care are included as allowable costs of the provider.

PART I: This section lists the total expenses of the home office organization. These expenses must tie to the home office organization's accounting documentation.

PART II: This section lists the other facilities that are served by the home office organization.

PART III: This section lists the home office expenses that are allocated to the Alaska provider and are included in the expenses listed on the Expense Worksheet.

PART IV: This section has the provider list the allocation basis of home office costs. Common allocation basis include, but are not limited to, a straight division between all facilities serviced or percent of labor hours.

Audited Financial Statements

Audited Financial Statements must be completed by an independent (non-stakeholder) CPA who is licensed in the state of Alaska. CPA's may practice/reside in another state, but must be licensed through the State of Alaska. Providers may do a professional License search at: http://commerce.state.ak.us/occ/OccSearch/main.cfm.

The total reported expense and revenue must tie to the Audited Financial Statements (AFS) and Post Audited Working Trial Balance. If reported expense and revenue totals do not agree between the forms, documentation must be provided to explain/support the differences.

Post Audit Working Trial Balance

The Post Audit Working Trial Balance is the list of account balances after all audit adjustments have been made.

The total reported expense and revenue must tie to the Audited Financial Statements

(AFS) and Post Audited Working Trial Balance. If reported expense and revenue totals do not agree between the forms, documentation must be provided to explain/support the differences.

The Post Audit Working Trial Balance must include a reconciliation to the Expense Worksheet by cost report line.