

Alaska Department of Health and Social Services
Cost Survey
Instructions

General Information

This cost survey must be used to report costs in accordance with 7 AAC 145.535. The survey document is designed for use by both simple and complex providers of Medicaid Personal Care Attendant (PCA) 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 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 Cost Survey and AFS are 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 4 Medicaid provider numbers. 3 are HCB provider numbers and one is a non-PCA/HCB Medicaid provider number.

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

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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.**

A complete cost survey includes:

1. Completed Cost Survey, 2011 document with all worksheets:
 - a. Certification
 - b. Expense Worksheet
 - c. Revenue and Statistics Worksheet
 - d. Related Party Worksheet
 - e. Buildings Worksheet
2. Audited Financial Statements (AFS);
3. Post audit working trial balance; and
4. 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.
5. Report of allocated home office costs if appropriate.

Certification

Provider Name, Administrative address – Provide the name of the provider and the administrative (business) address in the green shaded box.

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 expenses of the provider 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 – Non Waiver Services
- 4) Non-healthcare and Other Cost Centers

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 February 1, 2012

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 3: Report the costs of administering the consolidated providers operations on lines 1 through 3. 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.

Lines 4 and 5: Building/s and Maintenance. These costs include depreciation, rent, lease, maintenance, and repair. The provider may choose to report **all** of the consolidated providers Building and Maintenance costs on lines 6 and 7 **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: A organization with \$300,000 of expense in buildings and maintenance for the consolidated provider's operations may choose to report the entire amount on lines 6 and 7 **or** it may choose to track and report the \$300,000 by each area of usage. General Service Costs \$60,000 (lines 5-6); Grant Costs \$20,000 (line 14); Group Home \$150,000 (line 32); Respite – Per Diem \$50,000 (line 44); and Non-Healthcare/Other \$20,000 (line 92).

NOTE: Costs from lines 1 through 7 will be allocated (distributed) to other cost areas in order to determine the complete cost of each service.

Lines 8 through 17: 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(c) are reported on these lines.
- 2) All of the costs related to the provision of grant funded services should be reported on line 14.
- 3) Line 17 "All Other" will be used to report all costs that do not meet the reimbursable requirements of 7 AAC 145.533 except for those costs that are reported in the "Other" section line 85 - 90.

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.

Lines 18 through 90: 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 31 through 33. Note: line 32 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 6 and 7.

PCA Direct Care Cost

Lines 91 through 93: These lines are used to report the expenses that are directly related to the provision of Personal Care Attendant services.

Note: line 92 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 6 and 7.

Other- Healthcare (non-PCA/Waiver)

Lines 94 through 96 – These lines are used to report direct expenses of non-PCA/Waiver healthcare services. Any costs related to Waiver clients related to SME, Private Duty Nurse, or Environmental Modifications should also be reported here.

Example - consolidated 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 5.

Note: line 95 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 6 and 7.

Other- Non-Healthcare

Lines 97 through 99 – These lines are used to report direct expenses of all other expenses. These are related to other operations of the consolidated 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 5. Only direct expenses are reported here.

Note: line 98 (Buildings and Maintenance) should only be used if the provider is NOT reporting all Building and Maintenance expense on lines 6 and 7.

Total expenses must tie to the consolidated providers Audited Financial Statements and Working Trial Balance.

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

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must be reported here. The total reported revenue must tie to the Audited Financial Statements (AFS).

Revenues and units of service must be reported by service category (procedure code). Both total and Medicaid must be reported. Procedure code categories are provided. Units of service and revenues must be reported before any adjustments (bad debt, discounts, other).

Revenues generated which are not related to HCB waiver or PCA services must be reported in the “Other” section.

PART II – 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 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. The provider should consult 7 AAC 145.537, 7 AAC 145.535(f),(g) and 7 AAC 160.990(b)(83) before completing this section.

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.

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,
- 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 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.

Buildings Worksheet

This spreadsheet is used to identify each building owned, rented, or leased by the consolidated provider. All of the consolidated 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 consolidated 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 consolidated 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 consolidated 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 consolidated 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

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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.