5160-3-20 **Nursing facilities (NFs) : medicaid cost report filing, disclosure requirements, and records retention.**

In addition to the provisions contained in sections 5165.10 through 5165.109 of the Revised Code, the following provisions apply.

(A) For reporting purposes NFs shall use the chart of accounts for NFs as set forth in rule 5160-3-42 of the Administrative Code, or relate its chart of accounts directly to the cost report.

(B) Unless an extension is granted by the Ohio department of medicaid (ODM), NF cost reports should be filed electronically within ninety days after the end of the reporting period via the medicaid information technology system (MITS) web portal or other electronic means designated by ODM.

(1) For good cause shown, cost reports may be submitted within fourteen days after the original due date if written approval is received from ODM prior to the original due date of the cost report. Requests for extensions should be in writing and explain the circumstances resulting in the need for an extension.

(2) In the case of a NF that has a change of operator during a calendar year, the cost report by the new provider should cover the portion of the calendar year following the change of operator encompassed by the first day of participation up to and including December thirty-first.

(3) In the case of a NF that begins participation after January first and ceases participation before December thirty-first of the same calendar year, the reporting period should be the first day of participation to the last day of participation.

(4) Unless waived by ODM, the reporting period ends as follows:

(a) On the last day of the calendar year for a facility's year end cost report; or

(b) On the last day of medicaid participation or when the facility closes in accordance with paragraph (A)(1) of rule 5160-3-02 of the Administrative Code; or

(c) On the last day before a change of operator for an exiting provider.

(5) If a cost report is not received by the original due date, or by an approved extension due date if applicable, the provider may be assessed a late file penalty for each day a complete and adequate cost report is not received. The late file penalty may be assessed even if ODM has provided written notice of termination to a facility.

(a) The late file penalty is determined using the prorated medicaid days paid in the late file period multiplied by the penalty. The penalty is two dollars per patient day.

(b) The late file penalty period begins on the day after the original due date or on the day after the extension due date, whichever is applicable, and continues until the complete and adequate cost report is received by ODM or the facility is terminated from the medicaid program.

(c) The late file penalty is a reduction to the medicaid payment. No penalty is imposed during a fourteen-day extension granted by ODM.

(C) The desk review is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.

(1) A facility may revise the cost report within sixty days after the original due date without the revised information being considered an amended cost report.

(2) The cost report is considered accepted after the cost report has passed the desk review process.

(3) After final rates have been issued, a provider that disagrees with a desk review decision may request a rate reconsideration.

(D) ODM shall not charge interest under division (B) of section 5165.41 of the Revised Code based on any error or additional information that is not required to be reported.

(E) Cost reports shall be completed using accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter 5160-3 of the Administrative Code.

(F) Providers should identify all known related parties as set forth under paragraph (F) of rule 5160-3-01 of the Administrative Code.

(G) Providers should identify all of the following:

(1) Each known individual, group of individuals, or organization not otherwise publicly disclosed who owns or has common ownership as set forth under paragraph (F) of rule 5160-3-01 of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the facility; and

(2) Each corporate officer or director, if the provider is a corporation; and

(3) Each partner, if the provider is a partnership; and

(4) Each provider, whether participating in the medicare or medicaid program or not, which is part of an organization which is owned, or through any other device controlled, by the organization of which the provider is a part; and

(5) Any director, officer, manager, employee, individual, or organization having five per cent or more direct or indirect ownership or control of the provider, or who has been convicted of or pleaded guilty to a civil or criminal offense related to his involvement in programs established by Title XVIII (December 9, 2019), Title XIX (December 9, 2019), or Title XX (December 9, 2019) of the Social Security Act; and

(6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (F) of rule 5160-3-01 of the Administrative Code, in a managerial, accounting, auditing, legal, or similar capacity who was employed by ODM, the Ohio department of health, the office of attorney general, the office of the auditor of state, the Ohio department of aging, the Ohio department of developmental disabilities, the Ohio department of commerce, or the industrial commission of Ohio within the previous twelve months.

(H) Providers are required to provide upon request all contracts in effect during the cost report period for which the cost of the service from any individual or organization is ten thousand dollars or more in a twelve-month period; or for the services of a sole proprietor or partnership where there is no cost incurred and the imputed value of the service is ten thousand dollars or more in a twelve-month period.

(1) For purposes of this rule, "contract for service" is defined as the component of a contract that details services provided exclusive of supplies and equipment. It includes any contract that details services, supplies, and equipment to the extent the value of the service component is ten thousand dollars or more within a twelve-month period.

(2) For purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, that contracts with a provider to supply a service, either to the provider or directly to the beneficiary, where medicaid reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is ten thousand dollars or more in a twelve-month period.

(I) Financial, statistical and medical records (which shall be available to ODM or its authorized agent and to the U.S. department of health and human services and

other federal agencies) supporting the cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the cost report is filed if ODM issues an audit report, or six years after all appeal rights relating to the audit report are exhausted.

(1) Failure to retain the required financial, statistical, or medical records, renders the provider liable for monetary damages that are the greater of the following:

(a) One thousand dollars per audit; or

(b) Twenty-five per cent of the amount by which the undocumented cost increased the medicaid payments to the provider during the fiscal year.

(2) Failure to retain the required financial, statistical, or medical records to the extent that filed cost reports are unauditable will result in the penalty as specified in paragraph (I)(1) of this rule. Providers whose records have been found to be unauditable will be allowed sixty days to provide the necessary documentation. If, at the end of the sixty days, the required records have been provided and are determined auditable, the proposed penalty will be withdrawn. If ODM, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, ODM will impose the penalty as specified in paragraph (I)(1) of this rule.

(3) Refusing legal access to financial, statistical, or medical records will result in a penalty as specified in paragraph (I)(1) of this rule for outstanding medical services until such time as the requested information is made available to ODM.

(4) All requested financial, statistical, and medical records supporting the cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for facilities certified for participation in the medicaid program by this state within at least sixty days after request by the state or its subcontractors. The preferred Ohio location is the facility itself, but may be a corporate office, an accountant's office, or an attorney's office elsewhere in Ohio. The state or its subcontractors may conduct the audit or a review at the site of such records if outside of Ohio.

(J) When completing cost reports, the following guidelines shall be used to properly classify costs:

(1) All depreciable equipment valued at five thousand dollars or more per item and a useful life of at least two years or more is to be reported in the capital cost component set forth under the Administrative Code. The costs of any equipment leases executed before December 1, 1992 and reported as capital costs, shall

continue to be reported under the capital cost component. The costs of any new leases for equipment executed on or after December 1, 1992, shall be reported under the capital costs component. Operating lease costs for equipment that result from extended leases under the provision of a lease option negotiated on or after December 1, 1992 shall be reported under the capital cost component.

(2) Except for employers' share of payroll taxes, workers compensation, employee fringe benefits, and home office costs, allocation of commonly shared expenses across cost centers is not allowed. Wages and benefits for staff, including related parties, who perform duties directly related to functions performed in more than one cost center that would be expended under separate cost centers if performed by separate staff may be expended to separate cost centers based upon documented hours worked, provided the facility maintains adequate documentation of hours worked in each cost center. For example, the salary of an aide who is assigned to bathing and dressing chores in the early hours but works in the kitchen as a dietary aide for the remainder of the shift may be expended to separate cost centers provided the facility maintains adequate documentation of hours worked in each cost center.

(3) The costs of resident transport vehicles are reported under the capital cost component. Maintenance and repairs of these vehicles is reported under the ancillary/support cost component.

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