TO BE RESCINDED

5160-3-20 **Nursing facilities (NFs) and state operated intermediate care facilities for individuals with intellectual disabilities (ICFs-IID): medicaid cost report filing, disclosure requirements, and records retention.**

As a condition of participation in the Title XIX medicaid program, each NF and state operated ICF-IID shall file a cost report with the Ohio department of medicaid (ODM). The cost report must 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. Except as otherwise specified in this rule, the report shall cover a calendar year or the portion of a calendar year during which the NF or state operated ICF-IID participated in the medicaid program. In the case of a NF that has a change of operator during a calendar year, the report by the new provider shall 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, except as specified under paragraph (A)(1)(a) of this rule. In the case of a NF or state operated ICF-IID that begins participation after January first and ceases participation before December thirty-first of the same calendar year, the reporting period shall be the first day of participation to the last day of participation. 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.

(A) For good cause, as deemed appropriate by ODM, cost reports may be submitted within fourteen days after the original due date if written approval from ODM is received prior to the original due date of the cost report. Requests for extensions must be in writing and explain the circumstances resulting in the need for a cost report extension.

(1) For purposes of this rule, "original due date" means each facility's cost report is due ninety days after the end of each facility's reporting period. 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. The provider of a new facility is not required to file a cost report for the first calendar year the provider has a provider agreement if the initial provider agreement goes into effect after October first of that calendar year. In that instance, the provider shall file the first cost report for the immediately following calendar year; 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.

(2) If a facility does not submit the cost report within fourteen days after the original due date, or by the extension date granted by ODM or submits an incomplete or inadequate report, ODM shall provide immediate written notice to the facility that its provider agreement will be terminated in thirty days unless the facility submits a complete and adequate cost report within thirty days of receiving the notice.

(3) 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 penalty may be assessed even if ODM has provided written notice of termination to a facility. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by the penalty. The penalty shall be two dollars per patient day. The late file penalty period shall begin on the day after the original due date or on the day after the extension due date, whichever is applicable, and shall continue until the complete and adequate cost report is received by ODM or the facility is terminated from the medicaid program. The late file penalty shall be a reduction to the medicaid payment. No penalty shall be imposed during a fourteen-day extension granted by ODM as specified in paragraph (A) of this rule.

(B) The cost report shall include an addendum for disputed costs that may be used by a facility to set forth costs the facility believes may be disputed by ODM. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the cost report and/or chart of accounts for the cost report period in question (either in the reimbursable or the nonreimbursable cost centers). Any costs reported by the facility on the addendum may be considered by ODM in establishing the facility's prospective rate.

(C) ODM shall conduct a desk review of each cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. ODM shall notify each facility of any costs preliminarily determined not to be allowable and the reasons for the determination. The facility shall provide any documentation or other information requested by ODM and may submit any information it believes supports its reported costs.

(1) The desk review is an analysis of the provider's cost report to determine its adequacy, completeness, and accuracy and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review.

(2) 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.

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

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

(D) Except as provided in paragraph (D)(1) of this rule and not later than three years after a provider files a cost report with ODM under section 5165.10 of the Revised Code, the provider may amend the cost report if the provider discovers a material error in the cost report or additional information to be included in the cost report. ODM shall review the amended cost report for accuracy and notify the provider of its determination.

(1) A provider may not amend a cost report if ODM has notified the provider that an audit of the cost report or a cost report of the provider for a subsequent cost reporting period is to be conducted under section 5165.109 of the Revised Code. The provider may, however, provide ODM information that affects the costs included in the cost report. Such information may not be provided after the adjudication of the final settlement of the cost report.

(2) 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. ODM shall review the amended cost report for accuracy and notify the provider of its determination in accordance with section 5165.108 of the Revised Code.

(E) The annual cost report submitted by state-operated facilities shall cover the twelve-month period ending June thirtieth of the preceding year, or portion thereof, if medicaid participation was less than twelve months.

(F) Cost reports submitted by county and state-operated facilities may be completed using accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapter 5160-3 of the Administrative Code.

(G) Providers are required to identify all known related parties as set forth under paragraph (G) of rule 5160-3-01 of the Administrative Code.

(H) Providers are required to 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 (G) 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 direct or indirect ownership or control of five per cent or more [see paragraph (G) of this rule], 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 (January 2, 2013), Title XIX (January 1, 2014), or Title XX (July 1, 2015) 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 (G) 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.

(I) 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, who 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.

(J) 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 of the greater amount:

(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 shall result in the penalty as specified in paragraph (J)(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 shall impose the penalty as specified in paragraph (J)(1) of this rule.

(3) Refusing legal access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (J)(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. This requirement, however, does not preclude the state or its subcontractors from the option of conducting the audit and/or a review at the site of such records if outside of Ohio.

(K) 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 shall not be 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 for NFs.

Effective:

Five Year Review (FYR) Dates: 12/9/2019

Certification

Date

Promulgated Under:	119.03
Statutory Authority:	5165.02
Rule Amplifies:	5165.10, 5165.107, 5165.108, 5165.40, 5165.41
Prior Effective Dates:	12/30/1977, 08/03/1979, 07/01/1980, 01/19/1984, 03/29/1985, 12/31/1987 (Emer.), 03/30/1988, 07/01/1988, 12/20/1988 (Emer.), 03/18/1989, 12/28/1989 (Emer.), 03/22/1990, 10/01/1990 (Emer.), 12/20/1991 (Emer.), 03/19/1992, 06/30/1992, 12/01/1992, 06/26/1993, 12/30/1993 (Emer.), 03/18/1994, 12/31/1994, 12/28/1995, 03/20/1997 (Emer.), 05/22/1997, 03/31/1998 (Emer.), 12/17/1998, 09/12/2003, 07/01/2005, 02/09/2006, 10/24/2008, 02/15/2010, 03/19/2012, 01/10/2013, 01/23/2017