FYE 2024

GENERAL INSTRUCTIONS TO COST REPORT

HOSPITAL BASED NURSING FACILITY

(Revised June 2024)

This cost report form should be utilized by any Nursing Facility (to which costs are allocated from a hospital or other facility through a Medicare cost report cost finding on Medicare Worksheet B. If no costs are allocated to the Nursing Facility, the Medicaid cost report form for free-standing nursing home facilities should be used. Only those facilities that qualify as a hospital-based facility will be grouped as such. (See Policies and Procedures for Nursing Facility Services manual, Section 1002.1g.)

All financial information included in the cost report must be prepared in accordance with generally accepted accounting principles; however, where the Centers for Medicare & Medicaid Services Manual (CMS-15) differs from GAAP, CMS-15 will prevail. The cost report must be filed using the accrual basis of accounting covering the accounting period from July 1, 2023 to June 30, 2024. Where the provider's Medicare fiscal year ending dates are between January and April 30, 2024, cost reports must be submitted to the Department on or before September 30, 2024. Where the provider's Medicare fiscal year ending dates are between May and June 30, 2024, cost reports must be submitted to the Department on or before November 30, 2024. Where the provider's Medicare fiscal year ending dates are between July and December 31, 2024, cost reports must be submitted to the Department on or before September 30, 2024; the financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30, 2024 (i.e., if the provider's year end for Medicare purposes is September 30, the September 30, 2023 year end must be utilized in its entirety for the June 30, 2024 filing, not the September 30, 2024 year end or an allocation of two Medicare cost reports).

A copy of the completed electronic cost report and questionnaire along with the electronic copy of the recently filed applicable Medicare cost report and any final settled Medicare cost report(s) whose adjustments are flowed through this Medicaid cost report, including all schedules and attachments, must be submitted by September 30, 2024 or November 30, 2024, as described above. The Policies and Procedures for Nursing Facility Services manual indicates that if the cost reports are not filed by September 30, or November 30, the Department shall have the option of either terminating the provider agreement upon thirty (30) days written notice or imposing a penalty of $50 per day for the first thirty (30) days and a penalty of $100 per day for each day thereafter until an acceptable cost report is received by the Department. The only condition in which this penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services for the Department of Community Health prior to the September 30 or November 30 deadline. Since incomplete reports are subject to the same penalty as late filings, all facilities are encouraged to file by September 1, 2024, or November 1, 2024, to insure that no penalty is imposed. Copies of the various supporting documents required by certain schedules should be attached to both copies of the cost report. The supporting documents should be clearly labeled as to the schedule to which they refer.

Approval for extensions beyond the November 30, 2024 due date will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e. a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

A cost report must be prepared by each owner of a nursing facility if the facility was sold during the current period. Each owner should complete the cost report covering the period of their ownership of the nursing facility.

All cost reports (Medicaid, Medicare, and Final Settled Medicare) should be emailed as an attachment to nhcostreport@dch.ga.gov.

We encourage a careful review of all the instructions before starting to prepare cost report.

Please code the county number using the following list:

Code	Code	Code	Code	Code
001. Appling	033. Cobb	065. Grady	097. McDuffie	129. Sumter
002. Atkinson	034. Coffee	066. Greene	098. McIntosh	130. Talbot
003. Bacon	035. Colquitt	067. Gwinnett	099. Meriwether	131. Taliaferro
004. Baker	036. Columbia	068. Habersham	100. Miller	132. Tattnall
005. Baldwin	037. Cook	069. Hall	101. Mitchell	133. Taylor
006. Banks	038. Coweta	070. Hancock	102. Monroe	134. Telfair
007. Barrow	039. Crawford	071. Haralson	103. Montgomery	135. Terrell
008. Bartow	040. Crisp	072. Harris	104. Morgan	136. Thomas
009. Ben Hill	041. Dade	073. Hart	105. Murray	137. Tift
010. Berrien	042. Dawson	074. Heard	106. Muscogee	138. Toombs
011. Bibb	043. Decatur	075. Henry	107. Newton	139. Towns
012. Bleckley	044. DeKalb	076. Houston	108. Oconee	140. Treutlen
013. Brantley	045. Dodge	077. Irwin	109. Oglethorpe	141. Troup
014. Brooks	046. Dooly	078. Jackson	110. Paulding	142. Turner
015. Bryan	047. Dougherty	079. Jasper	111. Peach	143. Twiggs
016. Bulloch	048. Douglas	080. Jeff Davis	112. Pickens	144. Union
017. Burke	049. Early	081. Jefferson	113. Pierce	145. Upson
018. Butts	050. Echols	082. Jenkins	114. Pike	146. Walker
019. Calhoun	051. Effingham	083. Johnson	115. Polk	147. Walton
020. Camden	052. Elbert	084. Jones	116. Pulaski	148. Ware
021. Candler	053. Emanuel	085. Lamar	117. Putnam	149. Warren
022. Carroll	054. Evans	086. Lanier	118. Quitman	150. Washington
023. Catoosa	055. Fannin	087. Laurens	119. Rabun	151. Wayne
024. Charlton	056. Fayette	088. Lee	120. Randolph	152. Webster
025. Chatham	057. Floyd	089. Liberty	121. Richmond	153. Wheeler
026. Chattahoochee	058. Forsyth	090. Lincoln	122. Rockdale	154. White
027. Chattooga	059. Franklin	091. Long	123. Schley	155. Whitfield
028. Cherokee	060. Fulton	092. Lowndes	124. Screven	156. Wilcox
029. Clarke	061. Gilmer	093. Lumpkin	125. Seminole	157. Wilkes
030. Clay	062. Glascock	094. Macon	126. Spalding	158. Wilkinson
031. Clayton	063. Glynn	095. Madison	127. Stephens	159. Worth
032. Clinch	064. Gordon	096. Marion	128. Stewart	

SCHEDULE CP

Schedule CP is the certification required to be signed by the owner, corporate officer or administrator, as indicated on the schedule. Unsigned reports will not be accepted. The passcode issued by the Department must be entered to serve as the electronic signature. If you do not have a passcode, please send an email to nhpassword@dch.ga.gov to request a passcode for your facility. Further, a place is provided for the preparer of the cost report (if not an employee of the provider) to be identified. Where applicable, please provide the preparer's complete address and phone number.

SCHEDULE A

Part I - Inpatient Days - Total inpatient days by month are to be reported by form of payment (Medicare, Medicaid (FFS), Medicaid (CMO), or Private and Other) and by whether or not the patient is onsite or out on a leave/hospital stay (Hospital/Leave days for Medicaid recipients should only include those days reimbursable under the Medicaid Program). A patient day is the care of one patient during the period between the census-taking hour of two successive days. When a patient is admitted and discharged on the same day, this must be counted as one inpatient day. Column 1 should contain only Medicare recipient patient days. Column 2 should contain any Private pay & Other onsite patient days. Column 3 should contain any Private pay and Other Hospital/Leave patient days. Column 4 should contain any Medicaid (FFS) onsite patient days. Column 5 should contain any Medicaid (CMO) onsite patient days. Column 6 should contain any Medicaid Hospital/Leave days. Column 6 should be the total of columns 1, 2, and 4. Column 7 should be the total of columns 1, 2, 4 & 5. Column 8 should be totals of columns 3 & 6 across. Line 13, column 8 should also equal the sum of column 8, lines 1-12 for the applicable period. Please Note: Hospice days are considered private pay days. These days should be listed in column 2. See our Policies and Procedures manual for further information.

Part II - Bed Capacity - Total beds, as certified by the Standards and Licensure Unit of the Department of Human Resources, are to be listed in the spaces provided. Temporary changes in bed availability because of alterations, painting, etc., do not affect bed capacity. Distinct part facilities must provide bed capacity information separately for Nursing Facility and Hospital beds. Bed days available are determined by multiplying the number of beds available in the reporting period by the number of days in the period. Take into account increases or decreases in the number of beds available and the number days elapsed since the increase or decrease. As an example, if the number of certified beds increased from 50 to 100 as of September of the reporting period the calculation would be as follows:

$$\mathbf{50}\ \boldsymbol{beds\ for}\ \mathbf{92}\ \boldsymbol{days}\ =\ \mathbf{4{,}600}\ \boldsymbol{bed\ days\ available}$$
$$\mathbf{100}\ \boldsymbol{beds\ for}\ \mathbf{273}\ \boldsymbol{days}\ =\ \mathbf{27{,}300}\ \boldsymbol{bed\ days\ available}$$
$$\mathbf{365}\ \boldsymbol{days}\ =\ \mathbf{31{,}900}\ \boldsymbol{bed\ days\ available\ during\ the\ period}$$

Part III - Percent Occupancy - The percent occupancy should be computed for each category in which bed capacity information has been provided.

Part IV - Minimum Per Diem Semi-Private Rates as of Last Day of Reporting Period - The minimum per diem semi-private rates must include only those charges for services comparable to those included in the Medicaid patient rate. Refer to Section 901 of the policies and procedures manual for further information on charges includable in the Medicaid patient rate.

Part V – Breakdown of Medicare Advantage Days – Total Medicare Advantage days by month, the applicable reimbursement rate, and total revenue are to be reported. These patient days should not be deducted from the patient days reported in Part I.

SCHEDULE B

Sub-schedules B-1, B-2, and B-3 provide the means to accumulate the information required for Schedule B. Specific cross references to the pertinent sub-schedule and Medicare cost report are included in the schedule B format. All financial information listed must be determined under generally accepted accounting principles.

The basic format of the sub-schedules follows the standard chart of accounts detailed in the DCH's Uniform Chart of Accounts manual. As stated therein, all providers participating in the Medicaid Program must utilize this standard chart of accounts.

SCHEDULE B-1

Routine Services Revenues (Lines 1-7) and Ancillary Revenues (Lines 8-21) are self- explanatory. Line 7 should be equal to Schedule B, Line 1 and Line 21, Column 1 should be equal to Schedule B, Line 2. Charges refer to the regular rates established by the provider for services rendered to both beneficiaries and to paying patients. Charges should be related consistently to the cost of the services and uniformly applied to all patients whether inpatient or outpatient. All patients' charges used in the development of apportionment ratios should be recorded at the gross value; i.e., charges before the application of allowances and discounts deductions. (See CMS-15, Section 2206.1 for information on accrual of charges and Section 2204.1 for hospital-based physician's charges.) Please note that several new accounts have been added as ancillary revenue categories.

SCHEDULE B-1A

The purpose of this schedule is to calculate the Ancillary expense adjustments necessary to properly determine the Medicaid program's portion of ancillary services provided. Please make sure that costs and charges are properly matched in the appropriate columns of Schedule B-1A.

Line 1: The sum of the individual line items from Schedule B-2, Column 6, for each particular ancillary service should be entered here. (You may need to obtain this detail directly from the Medicare cost report.) If the amounts on this line do not agree with the appropriate amounts on Schedule B-2, submit a supplementary schedule reconciling the two amounts.

Line 2: Report the amount of any Schedule B-4 adjustments to Ancillary expenses for each particular type of ancillary service.

Line 3: This is the difference between Line 1 and Line 2. For the Therapy Room Overhead columns, these numbers should be the amounts calculated on Schedule B-5, line 12a.

Line 4: Total charges from Schedule B-1, Column 1, for each particular ancillary service should be reported on this line. (You may need to obtain this detail directly from the Medicare cost report.) This should be nursing home charges only. Total Charges for the Therapy Room Overhead columns should be the sum of the amounts entered for Physical, Speech, and Occupational Therapy.

Line 5: This is Line 3 divided by Line 4. The result is the cost to charges ratio. Include at least 4 digits to the right of the decimal point.

Line 6: Report Medicaid charges for each particular ancillary service from Schedule B-1, Column 2, for each particular type of ancillary service. Medicaid Charge should be recorded for Medicare Part B billable ancillary services for Medicaid eligible residents who are not covered by Medicare Part B or Private Insurance. (Medicaid charges must be accurately tracked. Estimates are not allowable). Medicaid Charges for the Therapy Room Overhead columns should be the sum of the amounts entered for Physical, Speech, and Occupational Therapy.

Line 7: Medicaid cost is calculated by multiplying Lines 5 and 6 for each particular type of ancillary service.

Line 8: Total patient days are originally reported on schedule A, Column 9, Line 13. Total patient days (the same number) should be reported for each type of ancillary service.

Line 9: Medicaid patient days are originally reported on Schedule A, Columns 4 and 5, Line 13. The number to report on Line 9 is the sum of Schedule A, Columns 4 and 5, Line 13. Total Medicaid patient days (the same number) should be reported for each type of ancillary service.

Line 10: Maximum reimbursable costs equal Medicaid cost (Line 7) times the ratio of total patient days to Medicaid patient days (Line 8 divided by Line 9).

Line 11: Compare the amounts on Lines 3 and 10. Enter the larger amount here.

Line 12: The amount of the Schedule B-4 adjustment is the difference between maximum reimbursable costs (Line 10) and the amount on Line 11. These amounts should be reported on Schedule B-4 and adjusted to reimbursable costs on Schedule B-2, Column 5.

SPECIAL NOTE: The costs of prescription drugs, Non-Emergency Transportation, Radiology, and Laboratory are not reimbursable under the Nursing Home Program. (See Chapter 900 of Policies and Procedures.) Costs and revenues related to these should not be included on Schedule B-1A. The costs should be removed using line 5 of Schedule B-4.

SCHEDULE B-2

(Revised June 2024)

The purpose of Schedule B-2 is to accumulate direct and indirect costs applicable to the hospital-based Nursing Facility in the format of Schedule B. The hospital's Medicare cost report is utilized to the extent possible. A detailed guideline for Schedule B-2 preparation is as follows:

Column 2 The amounts recorded direct to the Nursing Facility on the Medicare cost report, CMS Form 2552, Worksheet A, column 3 should be entered in this column. These direct costs should be properly classified among cost centers in accordance with the DCH's Chart of Accounts manual.

Column 3 The amounts that have been reclassified to or from the Nursing Facility on Medicare Worksheet A-6 should be entered in this column.

Column 4 The amounts that have been added to or subtracted from the Nursing Facility on the Medicare cost report Worksheet A-8 should be entered in this column.

Column 5 The amounts that have been allocated to the Nursing Facility in Medicare cost report Worksheet B, Part 1, should be entered in this column.

Column 6 Column 6 is completed by adding or subtracting the amounts in columns 3 through 5 to the amounts in column 2.

Column 7 Enter in Column 7 "New Capital Costs" allocated to the Nursing Facility as shown on Medicare Worksheet B, Part II, for the appropriate cost centers. The allocated amount should be inserted in Column 7, Line 37. Adding (deducting) Column 7 from Column 6 will remove depreciation from individual cost centers and reflect all property depreciation in the property and related cost center in Column 8.

Column 8 For all line items except Line 37, Column 8 is completed by subtracting depreciation expense from total Nursing Facility expenses (Column 6 minus Column 7). Line 37, Column 4 is completed by adding amounts in Columns 6 and 7.

Columns 9, 10 and 11 Enter in Column 9 adjustments to expenses made on Schedule B-4. See instructions to Schedule B-4 for types of adjustments needed. Enter in Column 10 adjustments to expenses as a result of final settled Medicare cost reports as calculated on Schedule B-8. See instructions for Schedule B-8. Column 11 is completed by adding or subtracting the adjustment to expenses shown in Columns 9 and 10 from total Nursing Facility expenses (Column 8 plus or minus Columns 9 and 10). Please note that "Employee Health and Welfare" should be included in the routine service cost center; however, if actual cost center salary expenses can be determined and properly documented, the employee benefits costs must also be distributed to the cost centers. Submit a supplementary schedule showing these distributions.

Please note that there are additional areas to detail all Nurse Aid Training and Testing (column 6, line 31) and Property and Related Expenses (column 6, line 39) claimed on Schedule B-2. Report all costs incurred for nurse aide training and testing in the area provided. The amount shown for costs may, or may not, be the same as revenue received. Do not report revenue received on this schedule. Only actual verifiable costs should be reported. These costs must meet the criteria established by DCH's Uniform Chart of Accounts manual. The total amount of this schedule should match to Line 31, Column 6 of Schedule B-2. In addition, there will be a final audit settlement made after actual expenses incurred are reviewed against reimbursement received from DCH. Therefore, all nurse aide training costs incurred should be adjusted out of Schedule B-2, Line 31, Column 9 via a B-4 adjustment. The detail of Property and Related Costs section should identify costs for P&R Expenses including: direct depreciation, property taxes, property insurance, equipment leases, and capital-related interest expenses. Using CMS Form 2552 and the Columns 2 through 5 of schedule B-2, property costs included in column 7 can be traced to direct and/or Medicare step-down costs from the hospital.

SCHEDULE B-3

This schedule should be utilized only if applicable amounts specifically related to the hospital- based Nursing Facility have not been included in Schedules B-1 or B-2.

SCHEDULE B-4

(Revised June 2024)

Substantially all adjustments will have been reflected in Medicare Worksheet A. This schedule will normally be used on a limited basis to reflect adjustments specifically required by the Medicaid program, such as those that may result from the specific guideline depreciable lives set forth by American Hospital Association (AHA). Please include prior year audit adjustments which offset current year cost. Any adjustments required should be listed and then reflected in Column 5 of Schedule B-2. Note that any additional adjustment would have to be an amount applicable to the Nursing Facility only, and not to the total hospital.

On June 6, 1990, the Board of Medical Assistance voted to disallow certain costs. Please refer to Chapter 1000 of the nursing home policies and procedures manual for specifics regarding these costs. Some of the non-allowable costs include lobbying expenses, memberships in civic organizations, certain out-of-state travel and certain vehicle depreciation and air transportation. In addition, 50% of membership association dues, certain legal fees and various advertising costs are non-allowable. Any of these costs included on the cost report should be adjusted out by a B-4 adjustment. If adjustments to allowable costs were made in connection with a recent Medicare audit, Schedule B-8 should be prepared. Any adjustment should be reflected directly on Schedule B-2.

If the hospital provides ancillary services to nursing home patients, the total cost of providing those services to all of the nursing home patients (as shown on form CMS 2552, Worksheet D, Part IV) should be shown as an adjustment to the nursing home's costs where these costs are not already included in the nursing home's direct costs where these costs are not already included in the nursing home's direct costs (as shown on Form CMS 2552, Worksheet A). These costs should also be included on Schedule B-1A.

SCHEDULE B-5

(Note that this schedule does not have to be prepared if there are no non-patient care areas or therapy rooms.)

For purposes of completing Schedule B-5, non-patient care area is defined as - any area of the facility that is used for activities that are either not covered by the Medicaid program or that the provider receives compensation solely from a third party payer, such as Medicare.

The purpose of Schedule B-5 is to isolate indirect expenses included in patient care cost centers related to non-patient care and therapy activities. Such Non-patient care activity expenses are not allowable costs for Medicaid reimbursement purposes and should be removed from the patient care cost centers. Examples of non-patient care areas are included in Schedule B-5. The non-Medicaid utilization portion of indirect expenses related to therapy activities is calculated on Schedule B-1A, using the amounts calculated on Schedule B-5. These amounts should also be removed from the patient care cost centers.

Detail instructions for the allocation of indirect expenses to non-patient care and therapy areas are as follows:

Line 1: Insert the total expenses, as adjusted, before allocation of indirect expenses for the cost centers from Schedule B-2. This amount will be used as the expense allocation basis in lines 2 through 13 below.

Lines 2 - 12*a*: Certain common non-patient care areas have been listed. This list is not all inclusive and space has been provided (Lines 5 through 11) to list any such areas peculiar to particular provider. Column 1 requires that the square feet of each non-patient care area and the patient care (in total) be listed so as to compute each area's percentage (%) relationship to the total. As an example:

	Sq. Ft.	% of Total
Rental (Sub-Lease)	100	5
Gift Shop	100	5
Non-Patient Care	200	10
Therapy Room	200	10
Patient Care	1,600	80
Total	2,000	100%

Based on the above, 5% of each cost center's total adjusted costs would be allocated to each of the non-patient care areas and 10% to the therapy room. The total allocated to each cost center for non-patient care areas (Line 12) would be transferred to Schedule B-2 as an adjustment to allowable costs. The total allocated to each cost center for the therapy room (line12a) should be transferred to Schedule B-1A to calculate the non-Medicaid utilization portion of the cost. Column 1a requires that pounds-of-laundry used in each non-patient care area and in the patient care area (in total) be listed so as to compute each area's percentage (%) relationship to the total. If pounds-of-laundry is used as an allocation statistic, at least 3 months of documented usage during the cost reporting period must have been obtained. The use of pounds-of-laundry is optional and can only be used for the distribution of Laundry costs. Square feet will be used when pounds-of- laundry is notselected.

Line 13: Insert the total patient care related facility square footage. This should include all patient care related areas that are fully enclosed and heated or cooled. Note that buildings not connected to the nursing facility that are used for patient care related activities may be included, as long as they meet the following criteria: the building must be fully enclosed, heated or cooled, constructed of like material as the nursing facility and located on the same campus as the nursing facility.

Line 14: Sum of Lines 12 and 13. The total amount allocated (Line 14) should agree with total expenses, as adjusted (Line 1).

Note that Schedule B-5 isolates only indirect expenses related to non-patient care and therapy activities. Any direct expenses (salary, supplies, etc.) applicable to such non-patient care activities should be (1) reflected on Schedule B-3, Part II, and thereby not require any adjustment because the amounts on Schedule B-3 are not included in allowable costs, or (2) listed as separate adjustments on Schedule B-4.

SCHEDULE B-6

(Revised June 2024)

The purpose of Schedule B-6 is to list all contractual services provided only to the Nursing Facility by non-related parties for amounts of $100 or more per month, or $1200 or more per annum. In addition, ownership equity information for listed entities with less than five owners should be provided. This schedule should include all such services covered by contractual agreement, written or oral, such as management services, medical or pharmaceutical services, therapists, dietitians, maintenance or laundry services, catering services, etc. Supplying of products such as raw food, office supplies, etc. should not be included. Only one service should be listed on each line. If additional lines are required, submit that information on additional copies of Schedule B-6.

SCHEDULE B-8

(Revised June 2024)

The purpose of Schedule B-8 is to compare the final settled Medicare cost report to the Medicare cost report utilized in preparing previously filed Medicaid cost reports. As these Medicare cost reports are settled, with the Medicare intermediary, Schedule B-8 should be completed for each "Final Settled Medicare Cost Report" since the last Medicaid cost report was filed. If multiple Medicare Cost Reports were settled, please select the button at the top of the page to select the number of cost reports that were settled. A detailed guideline for the Schedule B-8 preparation is as follows:

Column 2 The purpose of Column 2 of schedule B-8 is to accumulate the final "as adjusted" costs of the hospital based Nursing Facility from the final settled Medicare cost report. These costs are obtained from the appropriate Nursing Facility line(s) of the final settled Medicare cost report, Worksheet B, Part I.

Column 3 The purpose of Column 3 of Schedule B-8 is to report the depreciation expense of the hospital-based Nursing Facility from the final settled Medicare cost report. These costs are obtained from the appropriate Nursing Facility line(s) of the final settled Medicare cost report, Worksheet B, Part II.

Column 4 Column 4 is obtained by subtracting Column 3 from Column 2.

Column 5 For Medicaid cost reports affected by final settled Medicare cost reports since the last Medicaid cost report was filed, enter the amounts relating to the Nursing Facility, as they originally were shown on Medicaid Worksheet B-2 for that year, in this column. In effect, copy Medicaid Worksheet B-2, column 4 for the year settled.

Column 6 Column 6 is obtained by subtracting Column 5 from Column 4. These amounts are the effect of Medicare audit adjustments relating to the Nursing Facility and are transferred to Schedule B-2, Column 10.

SCHEDULE G AND G-1

Schedule G is a summary of the current year's nursing hours and employee benefits. Nursing hours should be itemized by employee hours and contractor hours. Employee benefits information has been moved from the questionnaire to Schedule G. The schedule is self-explanatory.

Schedule G-1 is used to list all compensation by position or title that exceed an annual salary of $60,060 or an hourly wage rate of $28.87. The following employees should also be reported on Schedule G-1 regardless of compensation, if they are directly expensed by the Nursing Facility:

1. Administrator
2. Assistant Administrator
3. Director of Nursing
4. Assistant Director of Nursing
5. Activities Director
6. Marketing Director
7. Staff Development Coordinator
8. Dietary Supervisor
9. Social Worker
10. Maintenance Director
11. Admissions Director
12. Clinical Liaison
13. Business Office Manager

All employees who perform job duties designed to increase patient utilization of the facility should also be listed regardless of compensation. If an employee performs non-allowable job duties, this should be indicated in column 8. The percentage of time spent on non-allowable job duties should be listed in column 9. Employees who are owners or non-owner related parties should also be listed. Cost center location for each listing must be included. (All individuals with portions of salary cost and/or hours at other facilities or Non-Medicaid entities must be listed with an asterisk designated after each amount.)

SCHEDULE H

All related party transactions listed in Medicare Worksheet A-8-1 must be considered in Schedule H.

A related party may be a corporation, partnership, or individual. (Refer to Chapter 10 of CMS-15 for an explanation of what constitutes a related party, and how this can affect reimbursable costs.) In general 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, supplies, etc. Further, costs applicable to services, facilities, and supplies furnished to the provider, by organizations related to the provider through common ownership or control, are includable in the allowable cost of the provider, at the cost to the related party. Such costs must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere. Where the cost of a related party is included in allowable cost, supporting financial statements of the related organization and calculations supporting the related party cost, for the cost report period must be furnished.

However, as stated in CMS-15, and the policies and procedures manual by reference, payments to related parties operating on an arm's length basis would be included in allowable costs on the basis of charges. Refer to Section 1010 of CMS-15 for further details on this exception to related party principle.

The following instructions indicate what is required to be included in Schedule H for related party transactions:

Item 1: This section is to summarize all the related parties listed in Medicare A-8-1 of the most recent Medicare cost report. The name of the related party (corporation, partnership, or individual) and the provider number, if applicable, should be listed in Columns 1 and 2. If the related party is a corporation or partnership, the stockholders or partners are required to disclose their names and ownership percentages numbers in Columns 3 and 4, respectively. If the related party is an individual repeat the name from Column 1 in Column 3. A brief description of services provided should be included in Column 5. Columns 6 and 7 should indicate the line number in Worksheet A of the Medicare report and the dollar amount included in expense. It will also be necessary to list in Columns 8 and 9 any other services provided (and applicable provider number) by the related party which are reimbursed through other Medicaid programs. As an example, a related party providing some form of contractual services may be a physician, pharmacist, physical therapist, etc. who also bills for services provided individually to recipients.

Item 2: The name(s) of the owner(s) (corporation, partnership or individual) and percentage owned should be listed in Column 1. If the owner is a corporation or partnership, the stockholders or partners and their ownership percentages should be listed in Columns 2 and 3, respectively. If the entity is an individual, repeat the name and percentage of ownership from Column 1 in Columns 2 and 3. Columns 4 and 5 should detail the name and provider number of any other nursing homes in which the owning entity, the individual owners or their relatives (parent, spouse, child, grandparent, sibling and in-law) have interest. Attach a separate page, if necessary. It will also be necessary to list in Columns 6 and 7 any other services provided (and applicable provider number) by the owning entity, or the individual owners, which are reimbursed through other Medicaid programs. As an example, an owner may be a physician, pharmacist, physical therapist, etc., who also bills for services provided individually to recipients.

Item 3: Each employee or officer who (1) receives compensation and (2) is an owner (either directly or through beneficial interest) or is a relative (as defined in instructions to Item 2 above) of an owner, the administrator or assistant administrator must be listed in this section. The relationship is to be described in Column 3. The administrator and assistant administrator must be listed regardless of ownership interest. In addition, all directors should be listed by individual and the total directors fees listed in Column 6 should agree with that in Medicare worksheet A. If they are not a related party show a "not applicable" (N/A) in Column 3 under Item 3. The total number of directors' meetings attended should be listed in Column 7. Total other compensation must include the amount of compensation resulting from the personal use of autos, lodgings or other benefits not included in the total compensation amount.

GENERAL AND PROFESSIONAL LIABILITY INSURANCE INFORMATION (GLPL)

The purpose of the GL/PL questionnaire is to specify the GL/PL expenses incurred during the cost reporting period and the type(s) of policies (self-insurance trust, captive insurance, commercial insurance, other).

Self-Insurance Trust: The provider must meet the criteria outlined in CMS 15-2162.7 to expense the premiums paid on the insurance policy. If any of these criteria are not met, then the provider can only expense amounts paid for claims during the year.

Captive Insurance: The provider must meet the criteria outlined in CMS 15-2162.2 to expense the premiums paid on the captive insurance policy. If any of these criteria are not met, the expense is disallowed.

Commercial Insurance: The provider should determine whether a cost is allowable and how to classify the expense per HCFA 15-1 section 108 and DCH Policies and Procedures.

Costs for general and professional liability insurance expense, as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to the Administrative and General cost center Standard Per Diem. If the expense reported on the GLPL questionnaire does not cover the entire fiscal year, please indicate the periods included on Line A. Additionally, if GLPL expense is included in an account other than A&G, please indicate the amount reported elsewhere on Line C and the schedule and line where it is reported on Line D.

For Line B and Line C, the amount reported in W/S S-2, Part I of the hospital's Medicare Cost Report should be reported as Item 1 and the A&G Allocation percentage should be reported as Item 2. If any of the GL/PL expense was directly expensed to the SNF (either through internal allocations, Medicare W/S A-6 reclassifications or policies specifically covering the SNF), those amounts should be reported as Item 4. For Line C, Item 6 the allocation basis used to allocate the Losses reported on the hospital's Medicare Cost Report (Line 118.02) should described and/or quantified.

QUESTIONNAIRE

The purpose of the Questionnaire tab is to provide additional information related to Schedule A, Medicare cost reports, Insurance, Patient Trust Fund, and Fair Rental Value Projects.

Line 1: The provider should select Yes, or No in response to the question in Line 1. If No is selected, the provider should include an explanation with the cost report submission.

Line 2: The provider should select Yes or No in response to the question in Line 2. If No is selected, the provider should include an explanation with the cost report submission.

Line 3: The provider should select Yes or No in response to the question in Line 3.

Line 4: The provider should select Yes or No in response to the question in Line 4.

Line 5: The provider should select Yes or No in response to the question in Line 5.

Line 6: The provider should list all open Medicare cost reports not final settled.

Line 7: The provider should select Yes or No in response to the question in Line 7. If No is selected, the provider should include an explanation with the cost report submission.

Line 8: The provider should select Yes or No in response to the question in Line 8. If No is selected, the provider should include an explanation with the cost report submission.

Line 9.A: The provider should select Yes or No in response to the question in Line 9.A.

Line 9.B: The provider should select Yes or No in response to the question in Line 10. If Yes is selected, the provider should indicate whether an Initial Startup and FRVS Update Request Form was submitted and the date of submission.

Line 10.A: The provider should select Yes or No in response to the question in Line 10.A. If Yes is selected, the provider should indicate the types of coverage that are self-insured and whether the provider is claiming the contributions to the fund or the actual claims paid.

Line 10.B: The provider should select Yes or No in response to the question in Line 10.B. If Yes is selected, the provider should indicate the types of coverage that are insured through a captive insurance policy.

Line 11: The provider should indicate the beginning date, end date, and amount of lease, if applicable.

Line 12: The provider should utilize the table provided to itemize dues and subscriptions. Providers should refer to DCH 1002.1(k) to determine allowable dues and subscriptions.

Line 13: The provider should utilize the table provided to itemize any property taxes that are directly expensed to the nursing facility (included in the nursing facility's general ledger accounts, reclassified via Medicare W/S A-6 or internally allocated).

Line 14: The provider should utilize the table provided to itemize any insurance policies that are directly expensed to the nursing facility (included in the nursing facility's general ledger accounts, reclassified via Medicare W/S A-6 or internally allocated).

Line 15: The provider should report the total amount held in the patient trust funds account.

COVID-19 SUPPLEMENTAL SCHEDULES

The purpose of the COVID-19 supplemental schedules is to report expenses and revenues related to the COVID-19 pandemic.

COVID-19 Questionnaire: The provider should answer all questions by selecting the appropriate response from the drop down menu in column H. The responses on the questionnaire will determine which of the following supplemental schedules should be completed.

COVID Parts II – IV: Providers should complete the table included in Part II to identify resident day data for the COVID-19 period, specifically identifying days that included a positive COVID-19 diagnosis. Providers should complete the table included in Part III in order to determine the average net revenue per patient day. Providers should identify in Part IV the total beds during the COVID-19 period and total beds added, if any, during the COVID-19 period.

COVID Parts V a – VI a: The purpose of this schedule is to calculate the COVID-19 general and labor costs. Providers should complete this supplemental schedule if accounts were maintained in the general ledger to track COVID-19 expenses separately. If staffing hours related to COVID-19 care and treatment were tracked separately, Part VI a should be completed.

COVID Parts V b – VI b: The purpose of this schedule is to calculate the COVID-19 general and labor costs. Providers should complete this supplemental schedule if accounts were **not** maintained in the general ledger to track COVID-19 expenses separately. If staffing hours related to COVID-19 care and treatment were **not** tracked separately, Part VI b should be completed.

COVID Part VII: The provider should complete this supplemental schedule if funds from the Provider Relief Fund were accepted. The provider should list in the table provided any Federal, State, and Local COVID Relief Fund revenue, including grants and payroll protection loans.