FYE 2023
GENERAL INSTRUCTIONS TO COST REPORT
HOSPITAL BASED NF/ICF-ID
(Intermediate Care Facilities for Individuals with Intellectual Disabilities)
(Rev. 6/2023)

This cost report form should be utilized by any NF/ICF-ID (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 NF/ICF-ID, 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, 2022 to June 30, 2023. Where the provider's Medicare fiscal year ending dates are between July 1, 2022 and April 30, 2023, cost reports must be submitted to the Department on or before September 30, 2023. Where the provider's Medicare fiscal year ending dates are between May and June 30, 2023, cost reports must be submitted to the Department on or before November 30, 2023. 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, 2023, (i.e., if the provider's year end for Medicare purposes is September 30th, the September 30, 2022 year end must be utilized in its entirety for the June 30, 2023 filing, not the September 30, 2023 year end or an allocation of two Medicare cost reports). A copy of the completed electronic cost report and questionnaire along with theelectronic copy of the recently filed applicable Medicare cost report and any final settled Medicarecost report(s) whose adjustments are flowed through this Medicaid cost report, including all schedules and attachments, must be included with the submission of the Medicaid cost report in order for the cost report submission to be deemed complete by September 30, 2023, or November 30, 2023.

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 orimposing a penalty of $50 per day for the first thirty (30) days and a penalty of $100 per day foreach day thereafter until an acceptable cost report is received by the Department. The onlycondition 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 fileby September 1, 2023, or November 1, 2023, to insure that no penalty is imposed. Copies of thevarious 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, 2023 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) tobe 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 the 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 NF and ICF-ID. 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:

50 beds for 92 days = 4,600 bed days available
100 beds for 273 days = 27,300 bed days available
365 days = 31,900 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 A-1

Schedule A-1 requires bed capacity information for the hospital excluding the NF or ICF-ID facility. Refer to instructions to Schedule A for further guidance in completing this information.

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 1-14) and Ancillary Revenues (Lines 15-28) are self-explanatory. Line 14 should be equal to Schedule B, Line 1 and Line 28, Column 1 should be equal to Schedule B, Line 2. Charges refer to the regular rates established by the provider for services renderedto 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.

SPECIAL NOTE: The costs of prescription drugs, Non-Emergency Transportation, Radiology, and Laboratory are not allowable costs under the Nursing Home Program. (See Chapter 900 of Policies and Procedures.) The costs should be removed using line 5 of Schedule B-4.

SCHEDULE B-2
(Revised July 2013)

The purpose of Schedule B-2 is to accumulate direct and indirect costs applicable to the hospital-based NF or ICF-ID 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 in Column 1 of Worksheet C-1 of the HCFP should be recorded in this column.

Column 3 - Enter in Column 3 "New Capital Costs" allocated to the NF or ICF-ID as shown on Medicare Worksheet B, Part II, for the appropriate cost centers. This allocated amount should be inserted in Column 3, Line 37. Adding (deducting) Column 3 from Column 2 will remove depreciation from individual cost centers and reflect all property depreciation in the property and related cost center in Column 4.

Column 4 - For all line items except Line 37, Column 4 is completed by subtracting depreciation expense from total NF or ICF-ID expenses (Column 2 minus the sum of Column 4). Line 37, Column 4 is completed by adding amounts in Columns 2 and 3.

Columns 5, 6, and 7 - Enter in Column 5 adjustments to expenses made on Schedule B-4. See instructions to Schedule B-4 for types of adjustments needed. Enter in Column 6 adjustments to expenses as a result of final settled Medicare cost reports as calculated on Schedule B-5. See instructions for Schedule B-5. Column 7 is completed by adding or subtracting the adjustment to expenses shown in Columns 5 and 6 from total NF or ICF-ID expenses (Column4 plus or minus Columns 5 and 6). 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.

SCHEDULE B-2A

The purpose of Schedule B-2A is to detail all Property and Related Expenses claimed on Schedule B-2, column 2, line 39. Costs identified on Schedule B-2A should include direct depreciation, property taxes, property insurance, equipment leases, and capital-related interest expenses. Using CMS Form 2552, property costs included in column 2 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 NF or ICF-ID facility have not been included in Schedules B-1 or B-2.

SCHEDULE B-3A - NURSE AIDE TRAINING AND TESTING

Report all costs incurred for nurse aide training and testing on Schedule B-3A. 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 on schedule B-3A. These costs must meet the criteria established by DCH's Uniform Chart of Accounts manual. The total amount of this schedule should be transferred to Line 31, Column 2 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 6 via a B-4 adjustment.

SCHEDULE B-3B – VENTILATOR SERVICES PROGRAM COSTS SUMMARY

Report all costs incurred for the Ventilator Services Program on Schedule B-3B. An adjustment should be made to remove both total direct and indirect costs specifically associated with ventilation services from the cost report. Note that some costs may be already removed as part of adjustments through Schedule B-5 – Allocation of Indirect Expenses to Non-Patient Care Areas as a result of separate Ventilator Services Unit.

Ventilator services patient days should be recorded by form of payment (Medicare, Medicaid (FFS), or Private and Other) and by whether or not the patient is on-site or on a hospital/leave days 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.

SCHEDULE B-4
(Rev. 7/2016)

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 3 or 6 of Schedule B-2. Note that any additional adjustment would have to be an amount applicable to the NF or ICF-ID 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-5 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-8, 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).

QUESTIONNAIRE

The purpose of the Questionnaire is to provide additional information related to Schedule A, Schedule B-4, Medicare cost reports, and insurance.

Line 1 - The provider should select Yes, No, or N/A in response to the question in Line 1. If No is selected, the provider should include an explanation in the space provided at the end of the checklist.

Line 2 - The provider should select Yes, No, or N/A in response to the question in Line 2. If No is selected, the provider should include an explanation in the space provided at the end of the checklist.

Line 3 - The provider should select Yes, No, or N/A in response to the question in Line 3. If No is selected, the provider should include an explanation in the space provided at the end of the checklist.

Line 4 - The provider should utilize the table provided to identify the payor, period of time, rate, and applicable patient days. The total patient days should tie to Schedule A, Column 9, Line 13. The total revenue should tie to Schedule B-1, Line 14.

Line 5 - The provider should select Yes, No, or N/A in response to the question in Line 5. If No is selected, the provider should include an explanation in the space provided at the end of the checklist.

Line 6 - The provider should select Yes, No, or N/A in response to the question in Line 6. If No is selected, the provider should include an explanation in the space provided at the end of the checklist.

Line 7A - The provider should select Yes or No in response to the question in Line 7A. 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 7B - The provider should select Yes or No in response to the question in Line 7B. If Yes is selected, the provider should indicate the types of coverage that are insured through a captive insurance policy.