5123:2-7-12 **Intermediate care facilities - medicaid cost report, record retention, and disclosure requirements.**

(A) Each intermediate care facility shall file a medicaid cost report with the department. The medicaid cost report, including its supplements and attachments as specified under paragraphs (B) to (M) of this rule must be submitted electronically within ninety days after the end of the reporting period. Except as specified under paragraph (F) of this rule, the medicaid cost report shall cover a calendar year or the portion of a calendar year during which the intermediate care facility participated in the medicaid program. In the case of an intermediate care facility that has a change of operator during a calendar year, the medicaid cost 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 (H) of this rule. In the case of an intermediate care facility 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. The department shall make available the appropriate software for an electronically submitted medicaid cost report no later than sixty days prior to the initial due date of the medicaid cost report. For reporting purposes, intermediate care facilities shall use the chart of accounts as set forth in rule 5123:2-7-16 of the Administrative Code, or relate its chart of accounts directly to the medicaid cost report.

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

(1) For the purposes of this rule, "original due date" means each intermediate care facility's medicaid cost report is due ninety days after the end of each intermediate facility's reporting period. Unless waived by the department, the reporting period ends as follows:

(a) On the last day of the calendar year for the intermediate care facility's year-end medicaid cost report, except as provided in a paragraph (H)(2) of this rule; or

(b) On the last day of medicaid participation or when the intermediate care facility closes in accordance with rule 5123:2-7-02 of the Administrative Code; or

(c) On the last day before a change of operator; or

(d) On the last day of the new intermediate care facility's or new provider's first three full calendar months of participation under the medicaid

program which encompasses the first day of medicaid participation.

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

(3) During the thirty day termination period or any additional time allowed for an appeal of the proposed termination of a provider agreement, for each day a complete and adequate medicaid cost report is not received, the provider shall be assessed a late file penalty. The late file penalty shall be determined using the prorated medicaid days paid in the late file period multiplied by the penalty amount. The penalty amount shall be two dollars per patient day adjusted each July first for inflation during the preceding twelve months as stated in division (A)(2) of section 5111.26 of the Revised Code. The late file penalty period will begin the date the department issues its written notice and continue until the complete and adequate medicaid cost report is received by the department or the intermediate care 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 the department as specified in paragraph (B) of this rule.

(C) An addendum for disputed costs shall be an attachment to the medicaid cost report that an intermediate care facility may use to set forth costs the intermediate care facility believes may be disputed by the department. The costs stated on the addendum schedule are to have been applied to the other schedules or attachments as instructed by the medicaid 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 intermediate care facility on the addendum may be considered by the department in establishing the intermediate care facility's prospective rate.

(D) The department shall conduct a desk review of each medicaid cost report it receives. Based on the desk review, the department shall make a preliminary determination of whether the reported costs are allowable costs. Before issuing the determination, the department shall notify the intermediate care facility of any information on the medicaid cost report that requires further support. The intermediate care facility shall provide any documentation or other information requested by the department and may submit any information that it believes supports the reported costs. The department shall notify each intermediate care facility of any costs preliminarily determined not to be allowable and provide the reasons for the determination.

(1) The desk review is an analysis of the provider's medicaid 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 medicaid cost report without detailed verification and is designed to identify problems warranting additional review.

(2) An intermediate care facility may revise the medicaid cost report within sixty days after the original due date without the revised information being considered an amended medicaid cost report.

(3) The cost report is considered accepted after the medicaid 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.

(E) Except as provided in paragraph (E)(1) of this rule and not later than three years after a provider files a medicaid cost report with the department under section 5111.26 of the Revised Code, the provider may amend the medicaid cost report if the provider discovers a material error in the medicaid cost report or additional information to be included in the medicaid cost report. The department shall review the amended medicaid cost report for accuracy and notify the provider of its determination.

(1) A provider may not amend a medicaid cost report if the Ohio office of medical assistance has notified the provider that an audit of the medicaid cost report or a medicaid cost report of the provider for a subsequent medicaid cost reporting period is to be conducted under section 5111.27 of the Revised Code. The provider may, however, provide the Ohio office of medical assistance information that affects the costs included in the medicaid cost report. Such information may not be provided after the adjudication of the final settlement of the medicaid cost report.

(2) The department shall not charge interest under division (B) of section 5111.28 of the Revised Code based on any error or additional information that is not required to be reported under this paragraph. The department shall review the amended medicaid cost report for accuracy and notify the provider of its determination in accordance with section 5111.27 of the Revised Code.

(F) The annual medicaid cost report submitted by state-operated intermediate care 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.

(G) Medicaid cost reports submitted by county-operated and state-operated intermediate care facilities may be completed on accrual basis accounting and generally accepted accounting principles unless otherwise specified in Chapters 5101:3-3 or 5123:2-7 of the Administrative Code.

(H) Three-month medicaid cost reports:

(1) Facilities and providers new to the medicaid program shall submit a medicaid cost report pursuant to paragraph (B)(1) of this rule for the period which includes the date of certification and subsequent three full calendar months of operations. The new provider of an intermediate care facility that has a change of operator shall submit a medicaid cost report within ninety days after the end of the intermediate care facility's first three full calendar months after the change of operator.

(2) If an intermediate care facility described in paragraph (H)(1) of this rule opens or changes operators on or after October second, the intermediate care facility is not required to submit a year-end medicaid cost report for that calendar year.

(I) Providers are required to identify each known related party as defined in rule 5123:2-7-01 of the Administrative Code.

(J) 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 defined in rule 5123:2-7-01 of the Administrative Code, in whole or in part, any mortgage, deed of trust, property or asset of the intermediate care facility. When the intermediate care facility or the common owner is a publicly owned and traded corporation, this information beyond basic identifying criteria is not required as part of the medicaid cost report but must be available within two weeks when requested. Publicly disclosed information must be available at the time of the audit; 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, or who has been convicted of or pleaded guilty to a civil or criminal offense related to his or her involvement in programs established by Title XVIII of the Social Security Act, 42 U.S.C. 1395 (2010), Title XIX of the Social Security Act, 42 U.S.C 1396 (2010), or Title XX of the Social Security Act, 42 U.S.C. 1397 (2010); and

(6) Any individual currently employed by or under contract with the provider, or related party organization, as defined under paragraph (I) of this rule, in a

managerial, accounting, auditing, legal, or similar capacity who was employed by the department, the Ohio office of medical assistance, the Ohio department of health, the office of attorney general, the Ohio department of aging, the Ohio department of commerce, or the industrial commission of Ohio within the previous twelve months.

(K) Providers are required to provide upon request all contracts in effect during the medicaid 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, the audit provisions of 42 C.F.R. 420 subpart (D) (effective December 30, 1982), apply to these contractors.

(1) For the 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 which 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 the purposes of this rule, "subcontractor" is defined as any entity, including an individual or individuals, who contract 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.

(L) Financial, statistical, and medical records (which shall be available to the department, the Ohio office of medical assistance, and to the U.S. department of health and human services and other federal agencies) supporting the medicaid cost reports or claims for services rendered to residents shall be retained for the greater of seven years after the medicaid cost report is filed if the Ohio office of medical assistance 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 medicaid cost reports are unauditable shall result in the penalty as specified in paragraph (L)(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 the Ohio office of medical assistance, after review of the documentation submitted during the sixty-day period, determines that the records are still unauditable, the department shall impose the penalty as specified in paragraph (L)(1) of this rule.

(3) Refusing access to financial, statistical, or medical records shall result in a penalty as specified in paragraph (L)(1) of this rule for outstanding medical services until such time as the requested information is made available to the department or the Ohio office of medical assistance.

(4) All requested financial, statistical, and medical records supporting the medicaid cost reports or claims for services rendered to residents shall be available at a location in the state of Ohio for intermediate care 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 intermediate care 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.

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

(1) All depreciable equipment valued at five hundred 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 equipment acquired by an operating lease, including vehicles, executed before December 1, 1992, may be reported in the indirect care cost component if the costs were reported as administrative and general costs on the intermediate care facility's medicaid cost report for the reporting period ending December 31, 1992, until the current lease term expires. 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, which 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 the employer's 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 which 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 intermediate care 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 intermediate care 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 indirect care cost component.

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