THE STATE of ALASKA
GOVERNOR MIKE DUNLEAVY

Department of Health

OFFICE OF RATE REVIEW

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TO: All Interested Parties

FROM: Office of Rate Review

SUBJECT: Changes in Department of Health Medicaid Hospital and Long-Term Care Facility Reporting Manual

Listed below are the changes in the Department of Health (DOH) Medicaid Hospital and Long-Term Care Facility Reporting Manual dated August 2022, as compared to the Reporting Manual dated September 2005.

1. Facilities may now submit all documents electronically by email or request a secure file transfer link (available for large or secure files).

2. Instructions, Medicaid Forms and Certificate of Need (CON) Budget Forms have been revised to update titles, column heading, footers and line items to clarify required data and automatic calculations.

3. T-2, Page 2 was revised to add "To be completed by Facilities with a 9/30 year end."

4. SS-1A has been updated to include Administrative Wait Bed - Routine and Ancillary information.

5. SS-1B has been updated to add additional lines (Implantable devices charged to patients), rearranged and line names changed to align with Medicare Cost Report. Additional lines were added for facility convenience to align with their specific cost centers.

6. FS-3 has been updated to add additional categories for revenue and expenses.

Facilities are required by regulation to use the instructions and forms from the August 2022 reporting manual for all reports submitted to the Department after September 1, 2023.

STATE OF ALASKA
DEPARTMENT OF HEALTH
OFFICE OF RATE REVIEW
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MEDICAID HOSPITAL AND LONG-TERM CARE FACILITY REPORTING MANUAL

REPORTING INSTRUCTIONS AND FORMS

August 2022

STATE OF ALASKA
DEPARTMENT OF HEALTH
OFFICE OF RATE REVIEW
YEAR END REPORT INSTRUCTIONS

A. All data submitted on the year end forms is to be actual data for a facility's most recent fiscal year end. (For example: a 6/30/2021 facility would submit data for the period 7/1/2020 through 6/30/2021 on its year end report due no more than 150 days after the close of the facility's fiscal year.)

B. If Medicare has granted an extension on the time for filing the Medicare Cost Report beyond 150 days after the most recent fiscal year end, then all forms and schedules listed below must be filed with Medicaid within the extension allowed by Medicare.

C. Forms, schedules, and reports not submitted within the timelines as described in the paragraphs above will be considered not timely filed. See 7 AAC 150.150 Adjustment factors, for applicable penalties.

D: The Year end report can be submitted electronically through email or provider's can utilize the DOH, Office of Rate Review's (ORR) mode of secure file transfer by contacting staff at the ORR for more information. Electronic submission is the preferred method.

The following forms are a required part of the Year End Report submission package:

1. Uniform Medicare Cost Report as reported to the Medicare Intermediary, Form CMS-2552 or Form CMS-2540, as appropriate. **MEDICAID DATA (Title XIX Worksheets D pt V, D-3 & D pt I) MUST BE INCLUDED in the COST REPORT for all types (IP, OP, LTC & Swingbed) as appropriate.**

   The submission must include the electronic version of the cost report (PI and EC or SN version) submitted to CMS as well as the Medicare signature page (Wkst S, pt I-III) signed by Officer or Adminstrator of the Provider(s). Wkst S, pt I-III should have the same print run (date/time consistency). If a low utilization cost report is used, please contact us for more information on submission requirements.

The following Medicare Cost Report Supporting documentation:

a. Medicare Home Office Cost Statement, Form CMS-287, a copy of the finalized, most recent, Medicare Home Office cost statement, if applicable.

b. Any additional supporting schedules sent to the Intermediary with the Medicare Cost Report; for example, work papers supporting reclassification entries or other adjustments for 2552: Worksheets A, A-6, A-7, A-8 Series, B-1, C, D pt V, D-3, G-2, pt I and G-3. 2540: Worksheet A, A-6, A-7, A-8 Series, B-1, C, D pt I, G-2, pt I and G-3.

2. Audited Financial Statements specific to the facility and matching the period reported on the Medicare Cost Report.

3. Audit adjustments made by the Independent Financial Statement auditors or a statement that there are none.

4. Reconciliation of the Audited Financial Statements to the Medicare Cost Report, Worksheet A. This must include any variances clearly identified.

5. Post Audit Working Trial Balance in electronic format/Excel with account descriptions that clearly identify a cost center. For example: Revenue - Medicaid - Adults and Peds. The post audit working trial balance should include the Audit Adjustments made by the Independent Financial Statement Auditors.

6. Reconciliation of the Post Audit Working Trial Balance (PAWTB) to the Medicare Cost Report worksheet:

Wkst A - The reconciliation must include all expenses located in the PAWTB grouped by cost center, with explanations for amounts that are not included in the Wkst A or any additional amounts not included in the PAWTB.

Wkst A-6 - Provide either the PAWTB accounts or if using a calculation, provide all supporting documentation to support each reclass.

Wkst A-8 Series - Provide either the PAWTB accounts or if using a calculation, provide all supporting documentation to support each line.

Wkst C - The reconciliation must include all patient revenue located in the PAWTB grouped by cost center including, any nonreimburseable cost centers, with explanations for amounts that are not included in Wkst C.

Wkst G-Series - The reconciliation must include all accounts located in the PAWTB grouped by line number, with explanations for amounts that are not included in the Wkst G Series or any additional amounts that are not on the PAWTB.

7. The following Department of Health (DOH) Year End Report Forms:

   a. Form YET-1.
   b. Form T-2.
   c. Form T-15.
   d. Form SS-lA.
   e. Form SS-1B.
   f. Form SS-lC.
   g. Form FS-3.

See instructions for Medicaid forms listed below.

Medicaid Forms Instructions

YET-1 - Transmittal and Certification

This form must be read, understood, and signed by the chief administrative or financial officer of the health facility.

FORM T-2 - HEALTH FACILITY GENERAL INFORMATION

This form is used to report general information on the number of Admissions, Patient Days, Visits & Beds Available/Licensed for Services sorted by FYE-Total Facility and FYE-Medicaid.

FYE-Total Facility column reflects the total facility's patient utilization.

FYE-MEDICAID column reflects the Medicaid (Title **XIX)** utilization.

11. Number of Admissions during the FY by type.

12. Number of Patient Days by type. This section should tie to Medicare Worksheet S-3, pt I.

13. Number of Visits by type.

14. The number of beds available for service reflects the most current year of operation completed by the facility. The count should reflect the total number of beds available and the total number of licensed beds as of the facility's fiscal year end.

Lines 15-18 below do not apply to any facility with a 12/31 fiscal year end.

15. This line should be completed by Facilities with a 6/30 year end only. Column 1: add FY Total Facility information. Column 2: add FY Medicaid information.

16. This line should be completed by Facilities with a 6/30 year end only. Column 1: add FY Total Facility information. Column 2: add FY Medicaid information.

17. This line should be completed by Facilities with a 9/30 year end only. Column 1: add FY Total Facility information. Column 2: add FY Medicaid information.

18. This line should be completed by Facilities with a 9/30 year end only. Column 1: add FY Total Facility information. Column 2: add FY Medicaid information.

FORM T-15 - FACILITY BASED PHYSICIANS COMPENSATION

This form reports the financial arrangements with facility based physicians for the fiscal year.

Column 1 Report the provider billing identification number used to obtain reimbursement for the physician's services. Each physician must be listed on a separate line.

Column 2 Signify the type of financial arrangement by selecting the number listed below that best describes the financial arrangement.

1. A joint or salaried arrangement is one in which the health facility bills patients for the physician's services, and includes these revenues as health facility revenues. All department expenses are paid by the health facility. The health facility remits a fee or salary to the physician, which is included in health facility expense. **All payments to physicians are identified on the Medicare Cost Report, Worksheet A-8-2.**

2. A contracted department is an arrangement where the physician may pay any or all expenses of the department. The health facility bills patients for the departmental services and remits a fee to the physician. This fee would typically be designed to cover the expenses incurred by the physician plus his/her professional fee. **Payments to the physician are recorded as Professional Fees (regardless of the expenses incurred by the physician) and reported on the Medicare Cost Report, Worksheet A-8-2.**

3. A rental department is an arrangement whereby the physician bills patients for services rendered by the department and pays a rental fee for the use of departmental services. This rent is recorded as "other operating revenue" in the department and is offset against departmental expense in the reclassification process on the Medicare Cost Report.

4. An independent/separate department arrangement is an arrangement whereby the department functions are provided by an independent individual group of physician(s). Neither revenues or expense are incurred by the health facility. The health facility usually refers patients and/or specimens to the outside group, usually located on separate premises.

5. A physician clearing account arrangement is when the health facility bills patients for the physician's services, and records these billings as a liability. The subsequent payment to the physician is shown as a reduction of that liability. The hospital reflects neither revenue or expense relative to the professional services.

6. Other: If this description applies, please include a narrative explaining the type of financial arrangement in effect.

Column 3 List the cost center or department for which services were performed. If a physician performed services for more than one cost center, use a separate line to report the salaries and compensation included in each cost center.

Column 4 List name of physician or include brief description of type work done.

Columns 5 thru 8 List the total compensation paid by the facility for each cost center. This includes all components of physician compensation, i.e., monetary payments, fringe benefits, deferred compensation, physician professional membership fees, continuing education, malpractice and any other items of value.

FORM SS-1A - REVENUE AND EXPENSE ANALYSIS

This form reports all operating/non-operating revenues, expense and other required reporting items for the health facility.

LINE

1-8 Distribute the Patient Service Revenues between Inpatient routine and ancillary, Long Term Care routine and ancillary, Swing Bed/Admin Wait routine and ancillary, Outpatient, and Other Revenues earned from patient sources. Identify the types of "other" patient revenues.

9 Total lines 1 through 8 to equal total patient service revenues. This amount should be the same as SS-1B Col 1, line 50 & FS-3 line 6.

10 Enter the amount of Other Operating Revenues that have been reclassified or offset against departmental expenses. Include a schedule which details the Post Audit Working Trial Balance (PAWTB) accounts included in the total of the Other Operating Revenues, if multiple PAWTB accounts were combined.

11 Enter the amount of federal, state, regional or local taxes that are intended to or will be used to fund current operations.

12 Enter the monetary value of grants intended to be or which were used for current operations.

13 Enter the amount of revenue sharing the facility receives.

14 Enter all other revenue and provide a description.

15 Total lines 10-14.

16 Total of lines 9 and 15.

17-22 Enter non-operating revenues under the appropriate heading.

22 Enter the amount of Other Non-Operating Revenue not included in lines 17-21 (if multiple PAWTB accounts were combined, include a schedule which list the PAWTB accounts included in the total of reported under Other Non-Operating Revenues).

23 Total lines 15-22.

24-28 Enter Non-Operating expense in the lines provided.

28 Enter the amount of Other Non-Operating Expense not included in lines 24-27 (if multiple PAWTB accounts were combined, please include a schedule which list the PAWTB accounts included in the total Other Non-Operating Expense).

29 Total lines 23-28.

30 Subtract line 29 from line 23.

31 Enter amount of advocacy expenses. These include costs associated with advocacy activities, lobbying activities, and special assessments to fund the preparation of advocacy and position papers. Include a schedule of costs by PAWTB account number and amounts reported. This amount would be the amount removed on the Worksheet A-8 for advocacy activities, lobbying and special assessments to fund the preparations of advocacy and position papers.

32 Enter amount of membership dues, meeting fees, conference fees, and trade organization and association fees at 100%. Include a schedule of expenses by PAWTB account number and amount reported.

33 Enter amount of health care related training expenses sponsored by trade organizations or associations. Include a schedule of costs by PAWTB account number and amount reported.

34 Enter amount of plaintiff/appellant litigation expenses. Please schedule and reconcile amounts by PAWTB account number, amount, case name, and stage of litigation (e.g. "on going" or "resolved," etc.). Attach a copy of the final order showing that facility was prevailing party. Note that expenses incurred because of litigation not originally initiated by the facility are not subject to this requirement or 7 AAC 150.170 (b) (15).

FORM SS-1B - REVENUE SUMMARY

Column 1 Total facility gross revenue (acute and long term care) is taken from the facility's general ledger (includes charity care revenues, bad debts & contractuals). Total facility revenue should tie to the PAWTB total patient revenue. The amount on Line 50, should be the same as SS-1A line 9 & FS-3 line 6.

Column 2 Total long term care facility gross revenue is taken from the facility's general ledger (includes charity care revenues, bad debts & contractuals). The amounts in this column should not exceed those in column 5 for the same line.

Column 3 Gross revenue billed to Medicaid for inpatient hospital services is recorded here. The facility should use their own data contained in the general ledger. This should tie to Medicare Form D-3, Title XIX, Hospital.

Column 4 Gross revenue billed to Medicaid for outpatient hospital services is recorded here. The facility should use their own data contained in the general ledger. This should tie to Medicare Form D pt V, Title XIX, Hospital.

Column 5 Gross revenue billed to Medicaid for long term care services is recorded here. Ancillary charges for services provided to long term care patients is to be recorded in this column also. The facility should use their Medicaid patient log or the general ledger. This should tie to Medicare Worksheet D-3, Title XIX column 2, if using form 2552 or the ancillary section should tie to D pt I, Skilled Nursing Facility column 2, if using form 2540.

Column 6 Gross revenue billed to Medicaid for swing bed/administrative wait services is recorded here. Anything billed to Medicaid under revenue code 0194 and any ancillary charges associated with these patients, if billed to Medicaid should be recorded in this column. The facility should use their own data contained in the general ledger.

Note: The total of any line for columns 3-6 should not exceed corresponding line in column 1.

FORM SS-1C - FACILITY BASED PHYSICIAN'S REVENUE

This form discloses any Physician revenues which were included in revenue information reported on DOH Worksheet SS-1B. If physician revenues were not included in revenue information reported on DOH Worksheet SS-1B, indicate on the form but do not complete form.

Column 1 Indicate total facility based physician, acute and long term care, revenues by cost center.

Column 2 Indicate total long term care facility based physician revenues by cost center.

Columns 3 thru 6 Report facility based physician revenue for the Medicaid Program, by patient classification (inpatient, outpatient, long term and swing bed/admin wait) and by cost center.

FORM FS-3 INCOME STATEMENT

This form records patient services revenue, deductions from revenue, non-operating revenue, operating expense and non-operating expense. This form should tie to AFS. If it doesn't, add notes for variances.

LINE

1-5 Patient Service Revenue by type.

6 Add lines 1-5. Total Patient Services Revenue it should equal SS-1A line 9 & SS-1B, column 1, line 50.

7-10 Deduction to Revenue by type. The must be separated by type.

11 Add lines 7-10. Total Deductions to Revenue.

12 Line 6 minus line 11. Net Patient Services Revenue. This should tie to AFS Net Patient

13 Other Sources of Revenue. This should tie to AFS Other Revenue.

14 Add lines 12 & 13. Total Revenue. This should tie to AFS.

15-31 Operating Expense by category.

32 Add lines 15-31. Total Operating Expense. This should tie to the AFS Total Operating Expenses.

33 Other Non-Operating Expense.

STATE OF ALASKA
DEPARTMENT OF HEALTH
CERTIFICATE OF NEED (CON)
BUDGET FORMS INSTRUCTIONS

The Department of Health (DOH) CON Budget Submittal package forms need to be completed only by Facilities that have received a Certificate of Need (CON) for at least $5 Million per AS 18.07 and 7 AAC 150.160(f). Only capital outlays which have been approved in the CON application are subject to the budget process. The department will allow a change in the per-day rates calculated per 7 AAC 150.160(f)(4) and 7 AAC 150.170(b)(6).

If your facility meets the above requirements, please complete the following Budget forms:

1 **Form T-1 - Transmittal and Certification of CON Budget Forms**

2 **Form SS-3 - Other Direct Expenses Related to CON**

3 **Form SS-5 - Depreciation on Assets Requiring a CON**

If your facility does not have any capital projects which require a Certificate of Need of at least $5 Million OR if the project is for an Outpatient-only related project, your facility is not eligible for a CON add-on and no CON Budget Submittal package is to be submitted.

When to Submit?

Per 7 AAC 150.160(f)(1), once the project is materially complete and the Certificate of Occupancy has been received, the budget information may be submitted for a CON add-on. Per 7 AAC 150.130(b), if a facility requests inclusion of certificate of need capital, the facility shall submit its budget information to the department not less than 60 days before the beginning of the facility's fiscal year for subsequent CON add-on requests related to the same project.

If CON is for an Existing Facility

The facility must provide the Certificate of Occupancy and a reconciliation to the audited prior year financial statements identifying the assets shown on the financial statements and the assets upon which depreciation is claimed. The facility must also provide the following, if applicable to the CON: a detailed depreciation schedule identifying all assets related to the project, a description of the asset, asset life, cost, purchase date, in service date, and depreciation expense amount; all types of insurance and the payment schedules; all types of loans and the payment schedules; all types of rentals/leases and the payment schedules.

If CON is for a New Facility

The facility must provide the Certificate of Occupancy and the following, if applicable to the CON: a detailed depreciation schedule identifying all assets related to the project, a description of the asset, asset life, cost, purchase date, in service date, and depreciation expense amount; all types of insurance and the payment schedules; all types of loans and the payment schedules; all types of rentals/leases and the payment schedules.

CON Form Instructions

FORM T-1 - TRANSMITTAL AND CERTIFICATION OF CON BUDGET FORMS

This form must be read, understood, and signed by the Chief Executive Officer and/or the Chairman of the Governing Board of the health facility.

General Notes for Completing Form SS-3 and SS-5

If this is the first year of a CON budget submittal, data estimations/projections for the current year (i.e. FY2020) will be entered in Column 3, Prospective Payment Year.

If this is the second year of a CON budget submittal, data estimations/projections for the current year (i.e. FY2021) will be entered in Column 3, Prospective Payment Year, and previous year updated estimations/projections (i.e. FY2020) data in Column 1, Year One.

If this is the third year of a CON budget submittal, data estimations/projections for the current year (i.e. FY2022) will be entered in Column 3, Prospective Payment Year, and the two previous year's as follows: actual data for original CON year (i.e. FY2020) under Column 1, Year One, and updated estimations/projections for second year CON data (i.e. FY2021) under column 2, Year Two.

FORM SS-3 - OTHER DIRECT EXPENSES RELATED TO CON

This form is to be used for recording insurance, interest, and rental and lease costs. The data for Column 1, year 1, is estimated. The data for Column 2, year 2, is projected data. The data for Column 3, the prospective payment year, is projected data.

The line instructions are as follows:

Line	
1	Enter the Property Insurance cost amounts.
2	Enter other insurance paid not specifically shown as a line item. Describe the expense

in the space provided.

3 Total lines 1-2.

4 Enter the amount of interest paid on mortgage.

5 Enter the amount of interest paid on outstanding bonds to bondholders.

6 Enter the amount of interest paid on equipment.

7 Enter other interest paid for items not specifically shown as a line item. Describe the type of interest expense in the space provided.

8 Add lines 4-7.

9 Enter rental or lease amounts paid for buildings used to perform Health Care Services.

10 Enter rental or lease amounts paid for Housing of Staff.

11 Enter rental or lease amounts paid for equipment.

12 Enter total of lines 9-11.

FORM SS-5 - DEPRECIATION ON ASSETS REQUIRING A CON

This form accumulates the assets for land, land improvements, building, fixed equipment, movable equipment, leasehold improvements, and construction in progress. It also displays the accumulated depreciation and the depreciation expense (assigned and unassigned). The data for lines 1 - 10, year 1, is estimated. The data for lines 13 - 22, the year 2, is projected data. The data for lines 25 - 34, the prospective payment year, is projected data.

LINE

1-9 Enter the estimated amounts for year 1 from the general ledger by classification. Make sure to appropriately total the ending balance columns (columns 4 and 7). The amount of depreciation expense directly expended should be included in column 6. The amount allocated should be included in column 5. The sum of columns 5 and 6 is equal amount allocated should be included in column 5. The sum of columns 5 and 6 is equal to the total provision for depreciation (column 7).

10 Total lines 1-9.

11-12 No data required

13-21 Enter the year 2 projected amounts by general ledger classification. Make sure to appropriately total the ending balance columns (columns 4 and 7). The amount of depreciation expense directly expended should be included in column 6. The amount allocated should be included in column 5. The sum of columns 5 and 6 is equal to the total provision for depreciation (column 7).

22 Total lines 13-21.

23-24 No data required.

25-33 Enter the projected prospective payment year amounts for the prospective payment year by general ledger classification. Make sure to appropriately total the ending balance columns (columns 4 and 7). The amount of depreciation expense directly expended should be included in column 6. The amount allocated should be included in column 5. The sum of columns 5 and 6 is equal to the total provision for

34 Total lines 25-33.

Provide supporting schedules for columns 1, 2 and 3, lines 1-9, 15-22 and lines 25-33, which list the assets which comprise the additions and retirements in each major category for Year 1 estimated or and Year 2 and Prospective Payment Year projected.

Indicate which column 2 assets have been purchased to date and which are projected to be purchased by years end. For each asset, give an asset description, purchase or anticipated purchase expense and date, asset life, anticipated depreciation and department location.