

Sec. 4. (a) Each provider shall submit an annual financial report to the office not later than the last day of the fifth (5th) calendar month after the close of the provider's reporting year. The annual financial report shall coincide with the fiscal year used by the provider to report federal income taxes for the operation unless the provider requests in writing that a different reporting period be used. Such a request shall be submitted within sixty (60) days after the initial certification of a provider. This option may be exercised only one (1) time by a provider and must coincide with the fiscal year end for Medicare cost reporting purposes. If a reporting period other than the tax year is established, audit trails between the periods are required, including reconciliation statements between the provider's records and the annual financial report. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written ~~and electronic cost report (ECR) file~~ copy of their Medicare cost report that covers their most recently completed historical reporting period. ~~Nursing facilities that have been granted an exemption to the Medicare filing requirement to submit the ECR file by the Medicare fiscal intermediary shall not be required to submit the ECR file to the office.~~

(b) The first annual Financial Report for Nursing Facilities for a provider that has undergone a change of provider ownership or control through an arm's-length transaction between unrelated parties shall coincide with that provider's first fiscal year end in which the provider has a minimum of six (6) full calendar months of actual historical financial data. The provider shall submit their first annual financial report to the office not later than the last day of the fifth (5th) calendar month after the close of the provider's reporting year or thirty (30) days following notification that the change of provider ownership has been reviewed by the office or its contractor. Nursing facilities that are certified to provide Medicare-covered skilled nursing facility services are required to submit a written copy of their Medicare cost report that covers their most recently completed historical reporting period.

(c) The provider's annual financial report shall be submitted using forms prescribed by the office. All data elements and required attachments shall be completed so as to provide full financial disclosure and shall include the following as a minimum:

- (1) Patient census data.
- (2) Statistical data.
- (3) Ownership and related party information.
- (4) Statement of all expenses and all income, excluding non-Medicaid routine income.
- (5) Detail of fixed assets and patient-related interest bearing debt.
- (6) Complete balance sheet data.
- (7) Schedule of Medicaid and private pay charges in effect on the last day of the reporting period. Private pay charges shall be the lowest usual and ordinary charge.
- (8) Certification by the provider that:
 - (A) the data are true, accurate, related to patient care; and
 - (B) expenses not related to patient care have been clearly identified.
- (9) Certification by the preparer, if different from the provider, that the data were compiled from all information provided to the preparer by the provider and as such are true and accurate to the best of the preparer's knowledge.

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(10) Copy of the working trial balance that was used in the preparation of their submitted Medicaid cost report.

(11) Copy of crosswalk document used to prepare the Medicaid cost report that contains an audit trail documenting the cost report schedule, line number and column where each general ledger account is reported on the cost report.

(12) Any other documents deemed necessary by the office to accomplish full financial disclosure of the provider's operation.

(13) Schedule for SCU for Alzheimer's disease or dementia

(d) Extension of the five (5) month filing period shall not be granted.

(e) Failure to submit an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services within the time limit required shall result in the following actions:

(1) No rate review shall be accepted or acted upon by the office until the delinquent reports are received.

(2) When an annual financial report or Medicare cost report by nursing facilities that are certified to provide Medicare-covered skilled nursing facility services is more than one (1) calendar month past due, the rate then currently being paid to the provider shall be reduced by ten percent (10%), effective on the first day of the seventh (7th) month following the provider's fiscal year end and shall so remain until the first day of the month after the delinquent annual financial report or Medicare cost report (if required) is received by the office. No rate adjustments will be allowed until the first day of the calendar quarter following receipt of the delinquent annual financial report. Reimbursement lost because of the penalty cannot be recovered by the provider. If the Medicare filing deadline for submitting the Medicare cost report is delayed by the Medicare fiscal intermediary, and the provider fails to submit their Medicare cost report to the office on or before the due date as extended by the Medicare fiscal intermediary, then the ten percent (10%) rate reduction for untimely filing to the office as referenced herein shall become effective on the first day of the month following the due date as extended by the Medicare fiscal intermediary.

(f) Nursing facilities are required to electronically transmit MDS resident assessment information in a complete, accurate, and timely manner. MDS resident assessment information for a calendar quarter must be transmitted by the fifteenth day of the second month following the end of that calendar quarter. Extension of the electronic

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MDS assessment transmission due date may be granted by the office to a new operation attempting to submit MDS assessments for the first time if the:

- (1) new operation is not currently enrolled or submitting MDS assessments under the Medicare program; and
- (2) provider can substantiate to the office circumstances that preclude timely electronic transmission.

(g) Residents discharged prior to completing an initial assessment that is not preceded by a Medicare assessment or a regularly scheduled assessment will be classified in one (1) of the following RUG-III classifications:

- (1) SSB classification for residents discharged before completing an initial assessment where the reason for discharge was death or a transfer to a hospital.
- (2) CC1 classification for residents discharged before completing an initial assessment where the reason for discharge was other than death or a transfer to a hospital.
- (3) The classification from their immediately preceding assessment for residents discharged before completing a regularly scheduled assessment.

(h) If the office or its contractor determines that a nursing facility has incomplete MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the RUG-III group "BC1 - Unclassifiable".

(i) If the office or its contractor determines that a nursing facility has delinquent MDS resident assessments, then, for purposes of determining the facility's CMI, the assessment or assessments shall be assigned the CMI associated with the RUG-III group "BC2 - Delinquent".

(j) If the office or its contractor determines due to an MDS field audit that a nursing facility has unsupported MDS resident assessments, then the following procedures shall be followed in applying any corrective remedy:

- (1) The office or its contractor:
 - (A) shall audit a sample of MDS resident assessments; and
 - (B) determine the percent of assessments in the sample that are unsupported.
- (2) If the percent of assessments in the initial sample that are unsupported is greater than twenty percent (20%), the office or its contractor shall expand to a larger sample of residents assessments. If the percent of assessments in the initial sample that are unsupported is equal to or less than twenty percent (20%):

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- (A) the office or its contractor shall conclude the field portion of the MDS audit; and
- (B) no corrective remedy shall be applied.
- (3) For nursing facilities with MDS audits performed on the initial and expanded sample of residents assessments, the office or its contractor will determine the percent of all assessments audited that are unsupported.
- (4) If the percent of assessments for the initial and expanded sample of all assessment audited that are unsupported is greater than twenty percent (20%), a corrective remedy shall apply, which shall be calculated as follows:
 - (A) The administrative component portion of the Medicaid rate in effect for the calendar quarter following completion of the MDS audit shall be reduced by the percentage as shown in the table below:

MDS Field Audit for Which Corrective Remedy is Applied	Administrative Component Corrective Remedy Percent
First MDS field audit	15%
Second consecutive MDS field audit	20%
Third consecutive MDS field audit	30%
Fourth or more consecutive MDS field audit(s)	50%

- (B) In the event a corrective remedy is imposed, for purposes of determining the average allowable cost of the median patient day for the administrative component, there shall be no adjustment made by the office or its contractor to the provider's allowable administrative costs.
- (C) Reimbursement lost as a result of any corrective remedies shall not be recoverable by the provider.
- (5) If the percent of assessments for the initial and expanded sample of all assessments audited that are unsupported is equal to or less than twenty percent (20%):
 - (A) the office or its contractor shall conclude the MDS audit; and
 - (B) no corrective remedy shall apply.

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(k) Based on findings from the MDS audit, beginning on the effective date of this rule, the office or its contractor shall make adjustments or revisions to all MDS data items that are required to classify a resident pursuant to the RUG-III resident classification system that are not supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. Such adjustments or revisions to MDS data transmitted by the nursing facility will be made in order to reflect the resident's highest functioning level that is supported according to the MDS supporting documentation guidelines as set forth in 405 IAC 1-15. The resident assessment will then be used to reclassify the resident pursuant to the RUG-III resident classification system by incorporating any adjustments or revisions made by the office or its contractor.

(l) Upon conclusion of an MDS audit, the office or its contractor shall recalculate the facility's CMI. If the recalculated

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CMI results in a change to the established Medicaid rate, the rate shall be recalculated and any payment adjustment shall be made.

405 IAC 1-14.6-5 New provider; initial financial report to office; criteria for establishing initial interim rates

Sec. 5. (a) Rate requests to establish an initial interim rate for a new operation shall be filed by submitting an initial rate request to the office on or before thirty (30) days after notification of the certification date. Initial interim rates will be set at the sum of the average allowable cost of the median patient day for the direct care, therapy, indirect care, administrative, and eighty percent (80%) of the capital component. Prior to the provider's first annual rate review, the direct care component of the Medicaid initial interim rate will be adjusted retroactively to reflect changes, occurring in the first and second calendar quarters of operation, in the provider's case mix index for Medicaid residents and adjusted prospectively after the second calendar quarter to reflect changes in the provider's case mix index for Medicaid residents. Initial interim rates shall be effective on the certification date or the date that a service is established, whichever is later. In determining the initial rate, limitations and restrictions otherwise outlined in this document and 405 IAC 1-14.6 shall apply.

(b) Prior to the first annual rate review, the rate will be adjusted effective on each calendar quarter pursuant to SECTION 5(d) of this document to account for changes in the provider's case mix index for Medicaid residents. A provider will not receive a change in the medians for calculating its reimbursement rate until its first annual rate review, which shall coincide with the provider's first fiscal year end that occurs after the