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MOMENTUM

**2023 ANNUAL
MEETING & EXPO**

MARCH 7-8, 2023

Renaissance Schaumburg
Convention Center - Schaumburg, IL

**Medicaid Reimbursement and Cost Reports:
Improve Your Bottom Line**

Your Speakers

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Objectives

Illinois Medicaid
Nursing Facility
Reimbursement

Illinois Nursing
Facility Medicaid
Cost Report

Improve Your
Bottom Line:
Capital Report

ILLINOIS MEDICAID NURSING FACILITY REIMBURSEMENT

Review of Illinois Medicaid Reimbursement

- The reimbursement rate for nursing facilities in Illinois is comprised of three components:
 - Nursing & Direct Care Component
 - Support Services Component
 - Capital Component
- Each element of the rate is calculated independently; however, the facility will receive a daily rate which is the sum of the three parts
- Facilities depend on the revenue stream coming from all three components to remain in good financial standing
- Separate reimbursement is also available for Quality Incentive and CNA Wage Pass-Through

Current Status of the Three Components

Nursing & Direct Care Component

- Currently Updated Every Quarter based on submitted Minimum Data Set (MDS) data
- New reimbursement system in place effective July 1, 2022

Support Services Component

- Currently frozen at the rate calculated for period beginning 7/1/19 - based on expenses reported on the 2013 or 2014 cost reports (those reports on file as of 3/31/2015)

Capital Component

- Currently frozen based on capital expenditures and real estate taxes reported on the 1998 or 1999 cost reports
- The state currently allows for an exception to this freeze if certain criteria are met

ILLINOIS MEDICAID RATE THE NURSING RATE

Nursing Home Rate Reform and Bed Tax

- House Bill 246 was signed into law providing approximately \$700 Million in additional reimbursement annually
- \$515 Million of funding from an increased bed tax and Federal matching
- Prior rate system through June 30, 2022:
- \$1.50 per bed per day plus \$6.07 per non-Medicare census day.
- New rate system July 1, 2022: Tax based only on non-Medicare census days.
- The new tax will range from a low of \$7.00 to a high of \$22.40 per non-Medicare census day.
- The tax assessment for a facility will be dependent on its total annual number of Medicaid census days.

Bed Tax

Rate Tier Based on Number of Paid Medicaid Resident Days per Annum	
Rate	Number of paid Medicaid resident days per annum
\$ 10.67	0-5,000
19.20	5,001-15,000
22.40	15,001-35,000
19.20	35,001-55,000
13.86	55,001-65,000
10.67	65,001+
7.00	Non-Profit nursing facilities without Medicaid Certified Beds

Bed Tax



State of Illinois
Illinois Department of Healthcare and Family Services

LONG TERM CARE (SNF/ICF) PROVIDER MONTHLY ASSESSMENT REPORT

HFS Assessment Tax ID: 6010101 (7 digit number beginning with 6)

Facility Name: Hometown Provider

Address: 46 Meadow Lane

City: Hometown State: IL Zip: 62626

Initial report: ☒ Corrected report: ☐

Reporting Period: April 1, 20XX to April 30, 20XX Payment Due Date: July X, 20XX

Example

The table below is the census for the entire reporting period. Provide occupied bed days by level of care and primary payment sources.									
	1	2	3	4	5	6	7	8	9
	Level of Care	Medicaid	Medicaid MLTSS	Medicaid MMAI	Medicare Part A MMAI	Medicare Part A	Private Pay	Other	Total
1	SNF	200		150	150	600		300	1400
2	MCDD	200						200	400
3	ICF								
4	ICF/DD								
5	TOTAL	400		150	150	600		500	1800

Assessment Calculation

6	Number of Occupied Beds (Line 5 Column 9)	1800
7	Minus Number of Medicare Occupied Beds (Line 5 Sum of Columns 5 and 6)	750
8	Net Occupied Beds (Line 6 Minus Line 7)	1050
9	Assessment per Occupied Bed (Rate based on paid Medicaid beds per annum)	\$19.20
10	Assessment Amount Due (Multiply Line 8 by line 9 and round to the nearest dollar)	\$20,160.00

MAKE CHECK PAYABLE TO: HEALTHCARE AND FAMILY SERVICES

Please remit to: HFS/Bureau of Fiscal Operations

P.O. Box 19491, Springfield, Illinois 62794-9491

PAYMENT IS ENCLOSED: YES ☐ NO ☐ CHECK NUMBER _____

I have examined the contents of the accompanying report for the period ____/____/____ through ____/____/____ to the State of Illinois, and certify that, to the best of my knowledge and belief, the said contents are true, accurate and complete statements in accordance with applicable instructions. Intentional misrepresentation or falsification of any information on this report may be punishable by fine and/or imprisonment.

Nursing Component

- The facility rate is based on the MDS assessments that are required for each Medicaid eligible resident
- The MDS is a core set of elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment for all residents of nursing homes certified to participate in Medicare or Medicaid
- The MDS contains items that reflect the status of the resident's condition, including diagnoses, treatments, and functional status.

Steps in Calculating the Nursing Rate

New Nursing Rate Effective July 1, 2022

Base Payment (increase in new rate)

X

Average CMI (Changes to PDPM)

X

Statewide Adjuster

+

Payment Add-ons

TBI

Alzheimer's

SMI

Medicaid Utilization Add-on (for facilities with 70% or more Medicaid)

Staffing (adjusted quarterly based on Strive %)

=

Nursing Rate

Calculating the Nursing Rate

- Statewide Base Payment – Increases from \$85.25 to \$92.25 for July 1, 2022
- Statewide Adjuster Factor – 1.06 for all Regions
- Alzheimer/ Dementia resident add-on remains at \$0.63
- SMI resident add-on remains at \$2.67
- Traumatic Brain Injury resident add-on remains at \$5.00
- Medicaid Utilization add-on is new for July 1, 2022
 - \$4.00 per day add-on for facilities with 70% or greater Medicaid utilization
 - Based on paid days for rolling twelve months ending 9 months prior. January 1, 2023 based on twelve months ending March 31, 2022

Medicaid Utilization Add-On

Illinois Department of HealthCare and Family Services
Medicaid Utilization % Calculation
January 1, 2023 Rate Period

Medicaid Utilization % Calculation										
Provider Name	IDPH Facility ID	Medicare ID (CCN)	Day Period Begin	Day Period End	Medicaid FFS Days	Medicaid Managed Care Days (Non-MMAI)	Medicaid MMAI Days (estimated)	Total Medicaid Resident Days Per Annum	Total Occupied Bed Days	Medicaid Utilization %
			4/1/2021	3/31/2022	3,642	10,791	1,024	15,457	23,153	66.76%
			4/1/2021	3/31/2022	1,926	10,291	3,934	16,151	19,827	81.46%
			4/1/2021	3/31/2022	3,763	5,920	1,157	10,840	37,536	28.88%
			4/1/2021	3/31/2022	6,846	12,760	4,906	24,512	34,697	70.64%
			4/1/2021	3/31/2022	3,197	15,565	1,222	19,984	27,235	73.38%
			4/1/2021	3/31/2022	3,704	5,848	2,894	12,446	23,773	52.35%
			4/1/2021	3/31/2022	2,533	4,938	4,387	11,858	26,838	44.18%
			4/1/2021	3/31/2022	716	1,754	1,478	3,948	14,310	27.59%
			4/1/2021	3/31/2022	2,806	3,508	1,788	8,102	16,839	48.11%
			4/1/2021	3/31/2022	3,959	35,502	1,862	41,323	56,076	73.69%
			4/1/2021	3/31/2022	2,735	9,723	2,617	15,075	25,374	59.41%
			4/1/2021	3/31/2022	2,817	4,834	2,393	10,044	33,944	29.59%
			4/1/2021	3/31/2022	6,456	20,905	2,734	30,095	44,148	68.17%
			4/1/2021	3/31/2022	1,937	3,004	2,236	7,177	21,478	33.42%
			4/1/2021	3/31/2022	8,179	14,361	8,732	31,272	45,322	69.00%

Staffing Add-On

- Compares actual reported nursing hours to expected nursing hours based on case-mix and STRIVE
- The higher the percentage of actual hours divided by expected STRIVE hours, then the higher the staffing add-on amount
- Floor of 85% - Facilities that have less than 85% of actual nursing time to expected are reimbursed at 85%
- Staffing add-on ranges from a low at 85% of \$18.60 per day to a high at 125% and above of \$38.68 per day

Staffing Add-On

Staffing Incentive Per Diem Scale		
Reported Total Nursing Hours as a Percentage of Case Mix (STRIVE)		
Total Nursing Hours		Per Diem Payment
125% and Above	\$	38.68
124%	\$	38.48
123%	\$	38.28
122%	\$	38.08
121%	\$	37.89
120%	\$	37.69
119%	\$	37.49
118%	\$	37.29
117%	\$	37.09
116%	\$	36.89
115%	\$	36.69
114%	\$	36.49
113%	\$	36.30
112%	\$	36.10
111%	\$	35.90
110%	\$	35.70
109%	\$	35.11
108%	\$	34.51
107%	\$	33.92
106%	\$	33.32
105%	\$	32.73
104%	\$	32.13
103%	\$	31.54
102%	\$	30.94
101%	\$	30.35
100%	\$	29.75

100%	\$	29.75
99%	\$	29.01
98%	\$	28.26
97%	\$	27.52
96%	\$	26.78
95%	\$	26.03
94%	\$	25.29
93%	\$	24.54
92%	\$	23.80
91%	\$	23.06
90%	\$	22.31
89%	\$	21.57
88%	\$	20.83
87%	\$	20.08
86%	\$	19.34
85%	\$	18.60
84%	\$	17.85
83%	\$	17.11
82%	\$	16.37
81%	\$	15.62
80%	\$	14.88
79%	\$	14.29
78%	\$	13.70
77%	\$	13.12
76%	\$	12.53
75%	\$	11.94
74%	\$	11.35
73%	\$	10.76
72%	\$	10.18
71%	\$	9.59
70%	\$	9.00
Below 70%	\$	-

Staffing Add-On

Illinois Department of HealthCare and Family Services
Staffing Incentive Calculation
January 1, 2023 Rate Period

Staffing Incentive Calculation								
Provider Name	IDPH Facility ID	Medicare ID (CCN)	Reported Hours Footnote	Reported Hours	Case Mix Hours	Provider % of STRIVE	Round Down Provider % of STRIVE	Staffing Incentive Per Diem
			0	2.51161	3.32927	75.44%	75.00%	\$ 11.94
			0	2.72874	3.06684	88.98%	88.00%	\$ 20.83
			0	3.47118	3.19095	108.78%	108.00%	\$ 34.51
			0	2.99581	3.77011	79.46%	79.00%	\$ 14.29
			0	3.07514	3.87771	79.30%	79.00%	\$ 14.29
			0	2.64955	3.97118	66.72%	66.00%	\$ -
			0	5.13803	3.10413	165.52%	165.00%	\$ 38.68
			0	4.16185	3.50118	118.87%	118.00%	\$ 37.29
			0	3.01636	3.32404	90.74%	90.00%	\$ 22.31
			0	2.59979	3.49838	74.31%	74.00%	\$ 11.35
			0	4.76517	3.92486	121.41%	121.00%	\$ 37.89
			0	3.22671	3.44193	93.75%	93.00%	\$ 24.54
			0	3.19143	4.21465	75.72%	75.00%	\$ 11.94
			0	3.87915	3.54898	109.30%	109.00%	\$ 35.11
			0	2.6926	3.23308	83.28%	83.00%	\$ 17.11

Calculating the Nursing Rate

- There is a transition period from RUGS to PDPM.
 - On 7/1/22 rate was blended 80% RUGS and 20% PDPM
 - Each quarter PDPM percentage increases 20% and RUGs decreases 20%
 - July 1, 2023 rate is 100% PDPM based
 - If PDPM rate is higher than RUGS blended rate, then PDPM rate used

Quality Incentives

- Facilities share in \$17,500,000 quarterly pool based on STAR ratings.
 - 0-1 STARs = 0 weighting
 - 2 STARs = 0.75 weighting
 - 3 STARs = 1.5 weighting
 - 4 STARs = 2.5 weighting
 - 5 STARs = 3.5 weighting
- Weighting applied to 1/4 of the number of Medicaid paid days for year ending 9 months prior.
- Individual facility weighting divided by all total quality weighted Medicaid days determines the percentage of the \$17,500,000 pool allocated to the individual facility
- Payments calculated quarterly and paid monthly by both HFS and Managed Care Plans

CNA Wage Pass-Through

- Additional reimbursement available to compensate CNA's with over 1 year experience or certain promoted CNA's.
- Nursing homes implement a CNA pay scale meeting certain criteria and post the scale in the facility.
- Payments calculated quarterly and paid monthly by both HFS and Managed Care Plans

CNA Wage Pass-Through

Medicaid's share of resident days for year ending 9 months prior		CNA hours and status from the most recent published PBJ and quarterly facility-submitted CNA templates		Minimum pay scale subsidized amounts		Medicaid's share of quarterly estimated cost of CNA minimum pay scale/3 for monthly payment
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 1 year's experience	X	\$1.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 2 year's experience	X	\$2.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 3 year's experience	X	\$3.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 4 year's experience	X	\$4.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 5 year's experience	X	\$5.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours at 6+ year's experience	X	\$6.50	=	
#Medicaid Paid Days/ #Total Resident Days	X	#CNA hours with a promotion* *Max 15% of total CNA hours	X	\$1.50	=	
Total Monthly Payment					=	

ILLINOIS MEDICAID RATE THE SUPPORT RATE

Support Rate

- The support rate covers the general service and administration costs associated with operating the nursing home
- The support rate is taken directly from the annual cost report
- Expense totals from all qualifying cost centers from the cost report, after all adjustments, reclassifications, and allocations are made, flow into the rate calculation
- The total census days flow from the cost report into the support rate calculation
- There are also numerous inflationary multipliers, conversions to per-diem costs, and geographic percentiles that determine the rate

Cost Report Gross Numbers

- The support rate is based on the general service and general administration cost centers on the cost report
 - These are lines 1-8 and 17-27 on page 3
- Although numerous calculations occur before arriving at the final totals, the beginning costs will always be the dollar amounts from the facility's trial balance
- Care must be taken to ensure the correct trial balance line items are being classified into these (and all) cost centers so that proper totals are reported
- The cost report total revenues and total expenses must always reconcile to the financial statements

Sample Cost Report Page 3

STATE OF ILLINOIS						Report Period Beginning:		Ending:		Page 3	
Facility Name & ID Number						#					
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
Operating Expenses		Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF	USE ONLY
A. General Services		Salary/Wage	Supplies	Other	Total						
		1	2	3	4	5	6	7	8	9	10
1	Dietary										1
2	Food Purchase										2
3	Housekeeping										3
4	Laundry										4
5	Heat and Other Utilities										5
6	Maintenance										6
7	Other (specify):*										7
8	TOTAL General Services										8
B. Health Care and Programs											
9	Medical Director										9
10	Nursing and Medical Records										10
10a	Therapy										10a
11	Activities										11
12	Social Services										12
13	CNA Training										13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs										16
C. General Administration											
17	Administrative										17
18	Directors Fees										18
19	Professional Services										19
20	Dues, Fees, Subscriptions & Promotions										20
21	Clerical & General Office Expenses										21
22	Employee Benefits & Payroll Taxes										22
23	Inservice Training & Education										23
24	Travel and Seminar										24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice										26
27	Other (specify):*										27
28	TOTAL General Administration										28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)										29
*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.											
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.											

Sample Cost Report Page 4

						STATE OF ILLINOIS						Page 4
Facility Name & ID Number						#	Report Period Beginning:		Ending:			
V. COST CENTER EXPENSES (continued)												
		Cost Per General Ledger										
	Capital Expense	Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF	USE ONLY	
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation											30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	TOTAL Ownership											37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	TOTAL Special Cost Centers											44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)											45
*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.												

The Cost Centers of the Support Rate

Dietary	Food	Housekeeping	Laundry
Heat & Utilities	Maintenance	Administrative	Directors Fees
Professional Services	Dues, Fees, Subscriptions & Promotions	Clerical & General Office	Employee Benefits
In-service Training & Education	Travel & Seminar	Other Staff Transportation	Insurance

Cost Centers Not Included in Support Rate

Medical Director	Nursing & Medical Records	Therapy	Activities	Social Services
CNA Training	Program Transportation	Depreciation	Amortization	Interest
Real Estate Taxes	Rent-Facility & Grounds	Rent-Equipment	Medically Necessary Transportation	Ancillary Service Centers
	Barber & Beauty	Coffee & Gift Shop	Provider Participation Fee	

Adjustments & Reclassifications

- Through the preparation process of the cost report, numerous adjustments and reclassifications occur that increase or decrease the trial balance totals on the cost reports
 - Certain expenses are non-reimbursable and must be adjusted out of the report
 - Certain expense may need reclassification from one cost center to another
 - Transactions of the nursing home with related entities may require increases or decreases to the totals
- The support rate formula will adjust employee benefits, which are reported in the general administration section of the cost report
 - Adjusts for salaries classified as Health Care and Programs or Special Costs
 - This adjustment is not performed on the cost report itself

Actual Support Rate Calculation

- Facilities do not calculate their own support rate for HFS
- The cost reports are submitted to HFS reporting the trial balance amounts classified into the various cost centers and the detail of all adjustments, reclassifications, and related party effects are also reported
- It is very important to have the amounts accurate, classified correctly, and complete
- The allowable costs are converted into a per diem with limitations and add-ons based on the geographic area where the facility is located.

Improving The Bottom Line

- The cost report form does not calculate the support rate. Facilities should have an estimate of the support rate before submitting the cost report to HFS.
- When HFS updates the support rates at July 1, they utilize a March 31st cut off date for determining which report will determine a facility's support rate
 - For example, the current reports are based on the 2014 cost report, or the report on file as of March 31, 2015
- Even though rates are currently frozen based on the March 31, 2015 cost reports, a facility should estimate its rates for every year based on the cost reports
 - A facility with a 12/31 year end can utilize the one month extension to its advantage if the prior year cost report generated a higher reimbursement rate

ILLINOIS MEDICAID RATE THE CAPITAL RATE

Capital Component

- The capital component of the Medicaid rate is the one element of the rate that can be routinely increased
- The capital component of the overall rate includes provisions for costs related to the building, building improvements, building rent, equipment rent, real estate taxes, depreciation, interest, equipment, and vehicles
- From the cost report, only building and building improvement costs factor into rate increases. The other elements of the rate calculation are pre-determined add-ons based on bed size and location of the facility.
- It is important to ensure correct classification and reporting of fixed assets on the annual cost report to allow an opportunity to increase the capital rate

Capital Rate Setting

- The historical value of the capital rate will be inflated based on HFS tables utilizing the year in which this historical value was based
- This inflated value is then converted into a cost-per-bed by dividing by the number of licensed beds in the facility
- The cost per bed is then compared to the HFS's table for uniform building values based on the historical year and an allowable cost per bed is calculated
- This allowable cost is then converted into a per-diem rate and add-ons for equipment, vehicles, working capital and real estate taxes (if applicable) are incorporated
- The final number will be the capital rate

ILLINOIS NURSING FACILITY MEDICAID COST REPORT

Cost Report Filing and Due Dates

- 2022 Reports
- This report should cover the facility's fiscal year ending in 2022. It is due on September 30, 2022 or ninety days after the close of the facility's fiscal year, whichever comes later.
- 30-day extension may be requested, but must be received by HFS before the end of the ninety-day period following the close of the facility's fiscal year. Filing an extension may cause the facility to not meet a key filing date with regard to the usage of cost reports for rates.
- HFS Provider Notice Issued on February 8, 2023

Cost Report Filing and Due Dates

Provider Notice Issued 02/08/2023

[HFS](#) > [Medical Providers](#) > [Notices](#) > Provider Notice Issued 02/08/2023

Date: February 8, 2023

To: Enrolled Long Term Care Facilities: Nursing Facilities (NF), Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Supportive Living Program (SLP), Medically Complex for the Developmentally Disabled Facilities (MC/DD), and provisionally licensed Specialized Mental Health Rehabilitation Facilities (SMHRF)

Re: 2022 Long Term Care (LTC) Cost Report Due Date/Cut-Off Date

This notice informs Long Term Care (LTC) providers that Healthcare and Family Services (HFS) is allowing one extra month for the filing of the Illinois Medicaid LTC cost report. This is in addition to any other approved extensions that may be granted.

This change in the due date/cut-off date for the 2022 LTC cost reports is a result of potential delays caused by the ongoing public health emergency that is affecting various healthcare organizations throughout the State of Illinois. 2022 LTC cost reports that are filed by May 01, 2023 (instead of March 31, 2023) will still meet the qualifications of [89 Illinois Administrative Code Section 140.560](#) and be considered filed timely for rate setting purposes if the 2022 cost reports are used to set provider reimbursement rates. This extra month will also allow more time for LTC providers to comply with the new ownership reporting required under Article 5B-5 of the Public Aid Code [[305 ILCS 5/5B-5](#)].

Additional extension requests still need to be submitted within the three-month period after the facility's year end, if providers need another month in addition to the extra month allowed by HFS. For example, the extra month will make the December 31, 2022, cost reports due May 01, 2023. With an approved extension request submitted timely, the due date would be May 31, 2023.

2022 Changes to the Medicaid Cost Report

- Census - HFS Instructions for Page 2, Part B Columns:

Please provide the patient day data by using these categories:

The numbers tie to the columns in Section B of Page 2 of the cost report

2-Medicaid Fee for Service - Under Fee For Service, Medicaid pays providers directly for each service they provide.

3-Medicaid Managed Long Term Services and Supports (MLTSS) Waiver Program is a 1915(b) Managed Care Waiver.

4-5-Medicare-Medicaid Alignment Initiative (MMAI) demonstration program. These days should be reported by who is the primary payer, Medicaid or Medicare.

6-Private Pay - The patient is responsible for the payment of the in-patient care.

7-Medicare Part A is the primary payer for these patient days.

8-Other payment sources not listed. Include Medicare Part C here.

- 2021 Form

MOMENTUM
2023 ANNUAL MEETING & EXPO

2022 Changes to the Medicaid Cost Report

- 2022 Form

STATE OF ILLINOIS										Page 2																																																																																																																
Facility Name & ID Number										#	Report Period Beginning:	Ending:																																																																																																														
III. STATISTICAL DATA A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds											D. How many bed reserve days during this year were paid by the Department? (Do not include bed reserve days in Section B.)																																																																																																															
<table border="1"> <thead> <tr> <th></th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> <tr> <th></th> <th>Beds at Beginning of Report Period</th> <th>Licensure Level of Care</th> <th>Beds at End of Report Period</th> <th>Licensed Bed Days During Report Period</th> </tr> </thead> <tbody> <tr> <td>1</td> <td></td> <td>Skilled (SNF)</td> <td></td> <td>1</td> </tr> <tr> <td>2</td> <td></td> <td>Skilled Pediatric (SNF/PED)</td> <td></td> <td>2</td> </tr> <tr> <td>3</td> <td></td> <td>Intermediate (ICF)</td> <td></td> <td>3</td> </tr> <tr> <td>4</td> <td></td> <td>Intermediate/DD</td> <td></td> <td>4</td> </tr> <tr> <td>5</td> <td></td> <td>Sheltered Care (SC)</td> <td></td> <td>5</td> </tr> <tr> <td>6</td> <td></td> <td>ICF/DD 16 or Less</td> <td></td> <td>6</td> </tr> <tr> <td>7</td> <td></td> <td>TOTALS</td> <td></td> <td>7</td> </tr> </tbody> </table>												1	2	3	4		Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	1		Skilled (SNF)		1	2		Skilled Pediatric (SNF/PED)		2	3		Intermediate (ICF)		3	4		Intermediate/DD		4	5		Sheltered Care (SC)		5	6		ICF/DD 16 or Less		6	7		TOTALS		7	E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)																																																																		
	1	2	3	4																																																																																																																						
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period																																																																																																																						
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7		TOTALS		7																																																																																																																						
B. Census-For the entire report period. <table border="1"> <thead> <tr> <th></th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> <th>5</th> <th>6</th> <th>7</th> <th>8</th> <th>9</th> </tr> </thead> <tbody> <tr> <td></td> <td colspan="9"> Patient Days by Level of Care and Primary Source of Payment </td> </tr> <tr> <td></td> <td>Level of Care</td> <td>Medicaid Fee for Service</td> <td>Medicaid MLTSS</td> <td colspan="2">MMAI</td> <td>Private Pay</td> <td>Medicare Part A Only</td> <td>Other</td> <td>Total</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> <td>Medicaid Primary</td> <td>Medicare Primary</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>8</td> <td>SNF</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>8</td> </tr> <tr> <td>9</td> <td>SNF/PED</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>9</td> </tr> <tr> <td>10</td> <td>ICF</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>10</td> </tr> <tr> <td>11</td> <td>ICF/DD</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>11</td> </tr> <tr> <td>12</td> <td>SC</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>12</td> </tr> <tr> <td>13</td> <td>DD 16 OR LESS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>13</td> </tr> <tr> <td>14</td> <td>TOTALS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>14</td> </tr> </tbody> </table>												1	2	3	4	5	6	7	8	9		Patient Days by Level of Care and Primary Source of Payment										Level of Care	Medicaid Fee for Service	Medicaid MLTSS	MMAI		Private Pay	Medicare Part A Only	Other	Total					Medicaid Primary	Medicare Primary					8	SNF								8	9	SNF/PED								9	10	ICF								10	11	ICF/DD								11	12	SC								12	13	DD 16 OR LESS								13	14	TOTALS								14	F. Does the facility maintain a daily midnight census? G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES <input type="checkbox"/> NO <input type="checkbox"/>	
	1	2	3	4	5	6	7	8	9																																																																																																																	
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13	DD 16 OR LESS								13																																																																																																																	
14	TOTALS								14																																																																																																																	
C. Percent Occupancy. (Column 9, line 14 divided by total licensed bed days on column 4, line 7.)											H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																															
I. On what date did you start providing long term care at this location? Date started / /											J. Was the facility purchased or leased after January 1, 1978? YES <input type="checkbox"/> Date / / NO <input type="checkbox"/>																																																																																																															
K. Was the facility certified for Medicare during the reporting year? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, enter certified beds.											IV. ACCOUNTING BASIS ACCRUAL <input type="checkbox"/> MODIFIED CASH* <input type="checkbox"/> CASH* <input type="checkbox"/>																																																																																																															
L. Medicare Intermediary											M. Is your fiscal year identical to your tax year? YES <input type="checkbox"/> NO <input type="checkbox"/>																																																																																																															
N. Tax Year: Fiscal Year: * All facilities other than governmental must report on the accrual basis.																																																																																																																										

2022 Changes to the Medicaid Cost Report

- Net Inpatient Revenue detailed by Payer Source - HFS Instructions:

Detail of Inpatient Care Revenue by Payer Source

A new section has been added to page 19 of the cost report. This new section requires the “Inpatient Care Revenue” reported on line 3 of this page to be detailed by payer source. The total amount reported in the new section should agree with the amount reported on line 3.

2022 Changes to the Medicaid Cost Report

- 2021 Form

STATE OF ILLINOIS				Page 19
Facility Name & ID Number		#	Report Period Beginning:	Ending:
XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.				
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.				
		1		2
I. Revenue		Amount		Amount
A. Inpatient Care				
1	Gross Revenue -- All Levels of Care	\$	1	
2	Discounts and Allowances for all Levels	()	2	
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	3	
B. Ancillary Revenue				
4	Day Care		4	
5	Other Care for Outpatients		5	
6	Therapy		6	
7	Oxygen		7	
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	
C. Other Operating Revenue				
9	Payments for Education		9	
10	Other Government Grants		10	
11	CNA Training Reimbursements		11	
12	Gift and Coffee Shop		12	
13	Barber and Beauty Care		13	
14	Non-Patient Meals		14	
15	Telephone, Television and Radio		15	
16	Rental of Facility Space		16	
17	Sale of Drugs		17	
18	Sale of Supplies to Non-Patients		18	
19	Laboratory		19	
20	Radiology and X-Ray		20	
21	Other Medical Services		21	
22	Laundry		22	
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23	
D. Non-Operating Revenue				
24	Contributions		24	
25	Interest and Other Investment Income***		25	
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26	
E. Other Revenue (specify):****				
27	Settlement Income (Insurance, Legal, Etc.)		27	
28			28	
28a			28a	
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29	
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$	30	
II. Expenses				
A. Operating Expenses				
31	General Services		31	
32	Health Care		32	
33	General Administration		33	
B. Capital Expense				
34	Ownership		34	
C. Ancillary Expense				
35	Special Cost Centers		35	
36	Provider Participation Fee		36	
D. Other Expenses (specify):				
37			37	
38			38	
39			39	
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	40	
41	Income before Income Taxes (line 30 minus line 40)**		41	
42	Income Taxes		42	
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$	43	
III. Net Inpatient Revenue detailed by Payer Source				
44	Medicaid - Net Inpatient Revenue	\$	44	
45	Private Pay - Net Inpatient Revenue		45	
46	Medicare - Net Inpatient Revenue		46	
47	Other-(specify)		47	
48	Other-(specify)		48	
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	49	
* This must agree with page 4, line 45, column 4.				
** Does this agree with taxable income (loss) per Federal Income Tax Return? If not, please attach a reconciliation.				
*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.				
****Provide a detailed breakdown of "Other Revenue" on an attached sheet.				

2022 Changes to the Medicaid Cost Report

- 2022 Form

Facility Name & ID Number				STATE OF ILLINOIS				Page 19			
#				Report Period Beginning:				Ending:			
XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached. Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.											
				1				2			
I. Revenue				Amount				II. Expenses			
A. Inpatient Care								A. Operating Expenses			
1	Gross Revenue -- All Levels of Care	\$	1	31	General Services		31				
2	Discounts and Allowances for all Levels	(2	32	Health Care		32				
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$	3	33	General Administration		33				
B. Ancillary Revenue				B. Capital Expense							
4	Day Care		4	34	Ownership		34				
5	Other Care for Outpatients		5	C. Ancillary Expense							
6	Therapy		6	35	Special Cost Centers		35				
7	Oxygen		7	36	Provider Participation Fee		36				
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8	D. Other Expenses (specify):							
C. Other Operating Revenue				37			37				
9	Payments for Education		9	38			38				
10	Other Government Grants		10	39			39				
11	CNA Training Reimbursements		11								
12	Gift and Coffee Shop		12	40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$	40				
13	Barber and Beauty Care		13								
14	Non-Patient Meals		14	41	Income before Income Taxes (line 30 minus line 40)**		41				
15	Telephone, Television and Radio		15								
16	Rental of Facility Space		16	42	Income Taxes		42				
17	Sale of Drugs		17								
18	Sale of Supplies to Non-Patients		18	43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)\$		43				
19	Laboratory		19								
20	Radiology and X-Ray		20	III. Net Inpatient Revenue detailed by Payer Source for each line							
21	Other Medical Services		21	44	Medicaid Fee for Service	\$	44				
22	Laundry		22	45	Medicaid Managed Long Term Services and Supports (MLTSS)		45				
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)\$		23	46	MMAI-Medicaid is the Primary Payer		46				
D. Non-Operating Revenue				47	MMAI-Medicare is the Primary Payer		47				
24	Contributions		24	48	Private Pay		48				
25	Interest and Other Investment Income***		25	49	Medicare Part A		49				
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)\$		26	50	Other-(specify)		50				
E. Other Revenue (specify):****				51	Other-(specify)		51				
27	Settlement Income (Insurance, Legal, Etc.)		27	52	Other-(specify)		52				
28			28	53	Other-(specify)		53				
28a			28a	54	Other-(specify)		54				
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)\$		29	55	Other-(specify)		55				
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)\$		30	56	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	\$	56				

2022 Changes to the Medicaid Cost Report

HB0246 Enrolled

- 29 -

LRB102 10452 SPS 15780 b

- HB 246 Requirement:

1 by the Illinois Department for reasonable cause, be added to
2 the assessment due a penalty assessment equal to 25% of the
3 assessment due.

4 (d) Notwithstanding any other provision of this Article, a
5 provider who commences operating or maintaining a long-term
6 care facility that was under a prior ownership and remained
7 licensed by the Department of Public Health shall notify the
8 Illinois Department of any ~~the~~ change in ownership regardless
9 of percentage, and shall be responsible to immediately pay any
10 prior amounts owed by the facility. In addition, beginning
11 January 1, 2023, all providers operating or maintaining a

12 long-term care facility shall notify the Illinois Depar
13 of all individual owners and any individuals or organizations
14 that are part of a limited liability company with ownership of
15 that facility and the percentage ownership of each owner. This
16 ownership reporting requirement does not include individual
17 shareholders in a publicly held corporation. Submission of the
18 information as part of the Department's cost reporting
19 requirements shall satisfy this requirement.

2022 Changes to the Medicaid Cost Report

- Cost Report Instructions:

Schedule VII should be completed as follows:

Schedule A - Related Organizations

Non-Profit and Government-owned facilities may continue to use Page 6 to report ownership details. For-Profit facilities are required to use the new **Ownership-1 and Ownership-2** pages to provide ownership details of the facility operations. The related facilities should continue to be reported on the PG6-Supp pages as necessary. On the Ownership Listing pages, enter the full legal name (no nicknames) and middle initial of all individuals having **any** ownership in the nursing home (even those with less than 5% interest). Do not include prefixes in the first or last name fields. Suffixes followed by a comma and space may be entered in the last name fields (Smith, Jr). On the Page 6 Supplemental pages, enter the names of all related nursing and/or organizations as defined above.

Please use the "Ownership Listing" pages to list the owners. Please complete the information requested for each owner. This information is necessary to fulfill the requirements of HB 246 which was recently passed in the Illinois General Assembly. This ownership reporting requirement does not include individual shareholders in a publicly held corporation. Facilities with early year ends may also meet the HB 246 requirements by including the complete ownership listing in the cost report prior to 1/01/2023.

2022 Changes to the Medicaid Cost Report

- 2021 Form

STATE OF ILLINOIS

Page 6

Facility Name & ID Number

#

Report Period Beginning:

Ending:

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES	
Name	Ownership %	Name	City	Name	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)
1	V		\$			\$	\$
2	V						
3	V						
4	V						
5	V						
6	V						
7	V						
8	V						
9	V						
10	V						
11	V						
12	V						
13	V						
14	Total		\$			\$	\$ *

* Total must agree with the amount recorded on line 34 of Schedule VI.

2022 Changes to the Medicaid Cost Report

- 2022 Form

STATE OF ILLINOIS					Ownership Listing-1			
Facility Name								
	ID#							
	Report Period Beginning:							
	Ending:							
-Names of individual owners must be listed. (Full legal name (no nicknames) and middle initial)								
-Owners of companies must be listed instead of company names.								
-Names of trust beneficiaries must be listed.								
	First Name	M.I.	Last Name		Place of Residence	Ownership		
					City	State	Percentage	
1								1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12

2022 Changes to the Medicaid Cost Report

- Nursing Home Association Dues – Changes to Page 5, 22 and 21- Per HFS Instructions:

Nursing Home Association dues are allowable. However, the portion of dues that relates to lobbying or political action (PAC dues) is not allowable. **Please use Page 22 of the cost report to detail these dues. See Page 5A, lines 1 and 2 and Page 22, Question #2, #3 and #4 of the cost report form.** Trust fees are also a non-allowable expense.

Page 5A:

Lines 1 and 2 have been set up to adjust out Political Action Committee (PAC) and lobbying expenses included on the cost report. Line 2 should be used to remove other lobbying expenses not already reflected in the PAC contributions that have been identified within the dues paid to the nursing home associations. See Page 22 of the cost report form and Page 40 of these instructions for additional information.

2022 Changes to the Medicaid Cost Report

Page 22:

XX. General Information.

This schedule contains questions regarding several miscellaneous areas. Be sure to complete this schedule as the cost report will not be considered complete until all questions are properly answered.

Question #2 – Please use the drop down menu to select the applicable LTC associations to which dues were paid during the cost report year. Page 5A should be used to remove any Political Action Organization (PAC) Payments and/or expenses related to lobbying activities. List the allowable association dues on the lines here.

Question #3 – Please enter here the non-allowable payments or dues for the association(s) listed in Question #2 and any other PAC payments. The total of these payments is linked to the adjustments on Page 21, Schedule XIX, Section F. and Page 5A, Line 1.

Question #4 – This question totals the information entered for Questions #2 and #3. The total for this question is linked to the “Association Dues” line on Page 21, Schedule XIX, Section F.

2022 Changes to the Medicaid Cost Report

- 2021 Form

Facility Name & ID Number										STATE OF ILLINOIS										Page 22									
#										Report Period Beginning:										Ending:									
XX. GENERAL INFORMATION:																													
(1) Are nursing employees (RN,LPN,NA) represented by a union?															(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?														
(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount.															(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.														
(3) Did the nursing home make political contributions or payments to a political action organization? If YES, have these costs been properly adjusted out of the cost report?															(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? Indicate the amount. \$														
(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? If YES, what is the capacity?															(16) Travel and Transportation														
(5) Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period?															a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.														
(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ Line															b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. \$														
(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.															c. What percent of all travel expense relates to transportation of nurses and patients?														
(8) Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.															d. Have vehicle usage logs been maintained?														
(9) Are you presently operating under a sublease agreement? YES NO															e. Are all vehicles stored at the nursing home during the night and all other times when not in use?														
(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.															f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?														
															g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$														
(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ This amount is to be recorded on line 42 of Schedule V.															(17) Has an audit been performed by an independent certified public accounting firm? Firm Name:														
(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.															(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?														
															(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees.														

2022 Changes to the Medicaid Cost Report

- 2022 Form

Facility Name & ID Number										STATE OF ILLINOIS										Report Period Beginning:										Ending:										Page 22									
XX. GENERAL INFORMATION:										#																																							
(1) Are nursing employees (RN,LPN,NA) represented by a union?																				(9) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?																													
(2) Please list the ALLOWABLE PAYMENTS OR dues paid to provider associations on the lines below. Use the drop down list to identify the association.																				(10) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.																													
Association Name										Amount																																							
										Total																																							
(3) List the amount of NON-ALLOWABLE payments OR DUES made to PROVIDER ASSOCIATIONS OR political action organizations. The total amount for Question #3 will be adjusted out of the cost report on Page 5A, Line 1.																				(11) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ Has any meal income been offset against related costs? Indicate the amount. \$																													
										Total																																							
(4) EXHIBIT: Total payments OR DUES TO EACH ORGANIZATION LISTED ABOVE (2 and 3 combined)																				(12) Travel and Transportation																													
																				a. Are there costs included for out-of-state travel? If YES, attach a complete explanation.																													
																				b. Do you have a separate contract with the Department to provide medical transportation for residents? If YES, please indicate the amount of income earned from such a program during this reporting period. \$																													
																				c. What percent of all travel expense relates to transportation of nurses and patients?																													
																				d. Have vehicle usage logs been maintained?																													
																				e. Are all vehicles stored at the nursing home during the night and all other times when not in use?																													
																				f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?																													
										Total										g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$																													
(5) Indicate the total amount of both disposable and non-disposable incontinent expense and the location of this expense on Sch. V. \$ Line																				(13) Has an audit been performed by an independent certified public accounting firm? Firm Name:																													
(6) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? If NO, attach a complete explanation.																				(14) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?																													
(7) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ This amount is to be recorded on line 42 of Schedule V.																				(15) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. Attach invoices and a summary of services for all architect and appraisal fees.																													
(8) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? If YES, attach an explanation of the allocation.																																																	

2022 Changes to the Medicaid Cost Report

				STATE OF ILLINOIS				Page 21			
Facility Name & ID Number				#				Report Period Beginning: Ending:			
XIX. SUPPORT SCHEDULES											
A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name		Function	Ownership %	Amount	Description		Amount	Description		Amount	
				\$	Workers' Compensation Insurance		\$	IDPH License Fee		\$	
					Unemployment Compensation Insurance			Advertising: Employee Recruitment			
					FICA Taxes			Health Care Worker Background Check			
					Employee Health Insurance			(Indicate # of checks performed)			
					Employee Meals			Patient Background Checks			
					Illinois Municipal Retirement Fund (IMRF)*			Association Dues (total from pg 22, #4)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				\$							
B. Administrative - Other											
Description				Amount				Less: Public Relations Expense		()	
				\$				PAC and Lobbying payments		()	
								All non-allowable advertising		()	
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				\$	TOTAL (agree to Schedule V, line 22, col.8)		\$	TOTAL (agree to Sch. V, line 20, col. 8)		\$	
C. Professional Services					E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**			
Vendor/Payee		Type		Amount	Description	Line #	Amount	Description	Amount		
				\$			\$	Out-of-State Travel	\$		
								In-State Travel			
								Seminar Expense			
								Entertainment Expense	()		
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)				\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$	

2022 Changes to the Medicaid Cost Report

STATE OF ILLINOIS					Page 5A	
	ID#					
Report Period Beginning:						
Ending:						
					Sch. V Line	
	NON-ALLOWABLE EXPENSES		Amount	Reference		
1	Political Action Committee Payments	\$	0	20	1	
2	Other Expenses Related to Lobbying Activities				2	
3					3	
4					4	
5					5	
6					6	

IMPROVE YOUR BOTTOM LINE CAPITAL REPORT

Capital Component

- A facility can apply to “unfreeze” the capital rate when certain criteria are met:
 - A facility must have added at least 10% of their unique historical building and improvement costs since their last capital rate increase and increased their weighted average year of building and improvement costs by at least one year

OR

- A facility has increased its licensed bed capacity by 10% or more from the previous licensure
- The application to “unfreeze” the capital rate, or capital report, is timely filed with HFS

Increase Historical Building and Improvement Cost

- When a nursing facility is purchased or built, a certain amount of the purchase price or total construction costs are allocated to the land, building, building improvements, and equipment
- If an appraisal was not done, HFS will use the prior owner's land, building, and equipment costs to allocate the cost of the purchase price
- The costs of the land, building, building improvements and equipment are reported on the cost report

Increase Historical Building and Improvement Cost

- Through years of operation, the facility will naturally need to have various improvements completed on the facility
- As these costs are incurred, they are detailed on a yearly basis on the annual cost report
- Once the total cost of these improvements equals or exceeds 10% of the costs associated with the last capital rate increase, and the weighted average year of the building and improvements increases by one year, the facility qualifies to file a rate increase request

Capital Rate Increase Example

- Assume a nursing facility located in Chicago was built in 2015
- The construction costs were allocated as follows:
 - Building and Improvements: \$3,500,000
 - Land: \$250,000
 - Equipment: \$1,250,000
- In years 2016-2022, the facility added improvements as follows:

Year	Total Improvements
2016	\$25,000
2017	\$40,000
2018	\$175,000
2019	\$20,000
2020	\$10,000
2021	\$60,000
2022	\$500,000

Capital Rate Increase Example

- Based on the information given, the nursing home can check each year if they have made enough improvements to qualify for a rate increase
- The cost of the facility for capital rate purposes is \$3,500,000
- The facility needs to add \$350,000 of cumulative improvements to satisfy the 10% criteria
- Assume that the weighted average year from the last time the capital rate was set is 2015 (more to follow)

Year	Yearly Improvements	Cumulative Improvements
2016	\$25,000	\$25,000
2017	\$40,000	\$65,000
2018	\$175,000	\$240,000
2019	\$20,000	\$260,000
2020	\$10,000	\$270,000
2021	\$60,000	\$330,000
2022	\$500,000	\$830,000

Capital Rate Increase Example

- Based on the information given, the facility met the 10% criteria during 2022
- Illinois Medicaid guidelines set the cut-off date for each year at June 30th, unless the licensed beds increased by 10% or more.
- Now that the 10% is met, the facility can check if their weighted average year increased from the weighted average year from the last time the capital rate was set

Year	Yearly Building & Improvements	Cumulative Building & Improvements	Year X Cost	Cumulative Year X Cost	Weighted Average Year
2015	\$3,500,000	\$3,500,000	\$7,052,500,000	\$7,052,500,000	2015.00
2016	\$25,000	\$3,525,000	\$50,400,000	\$7,102,900,000	2015.01
2017	\$40,000	\$3,565,000	\$80,680,000	\$7,183,580,000	2015.03
2018	\$175,000	\$3,740,000	\$353,150,000	\$7,536,730,000	2015.17
2019	\$20,000	\$3,760,000	\$40,380,000	\$7,577,110,000	2015.19
2020	\$10,000	\$3,770,000	\$20,200,000	\$7,597,310,000	2015.20
2021	\$60,000	\$3,830,000	\$121,260,000	\$7,718,570,000	2015.29
2022	\$500,000	\$4,330,000	\$1,011,000,000	\$8,729,570,000	2016.07

Capital Rate Increase Example

- Looking back on the previous slide, we can see that the facility increased its weighted average year by 1 year in 2022
 - The number is always truncated, never rounded, thus 2015.99 would still be considered 2015
- The facility needs to meet both criteria to file for an exception to the freeze, so even if the weighted average goes up in a given year, the facility would still need to wait until they also reach the 10%
- Use caution when examining the weighted average year and basis for the 10% total because it could be determined based on the last time a capital rate was set and could also include a prior owner's building improvement costs
- All of this data can be tracked using Medicaid cost reports

Capitalization Thresholds

- All improvements prior to 2006 must be at least \$500 and repairs must be at least \$1,500
- All improvement and repairs with a date of 2006 and later must be at least \$2,500
- The HFS considers any costs lower than these thresholds to be repairs and maintenance or supplies and should be expensed on the associated row of the cost report
- Any amounts lower than the capitalization thresholds would be adjusted out of the building improvements upon HFS audit
- HFS's capitalization policy can be independent of a facility's protocol for their accounting and tax purposes
- In addition, the classification of assets may also be different, thus it is important to review for book and cost report differences

What Qualifies as Improvements

- HFS utilizes the “Estimated Useful Lives of Depreciable Assets” handbook by the American Hospital Association (AHA) and the “AICPA Hospital Audit Guide” to determine capital expenditures that are classified as building and improvements and what expenditures are classified as equipment
- The following slides depict categories of capital expenditures and selected examples that would and would not be included in building improvements for a capital rate increase
- The definitions are taken directly from the AHA handbook

Land Improvements

- “Land improvements are assets of an above ground or below ground nature, found in the land area contiguous to and designed for serving a health care facility. The asset cost would include a proportionate share of architectural, consulting and interest expense for newly constructed or renovated facilities”
 - Bumpers
 - Fencing
 - Flagpoles
 - Guard Rails
 - Landscaping
 - Lawn Sprinklers
 - Parking Lot
 - Septic System
 - Shrubs and Lawns
 - Signs
 - Trees
 - Underground Utilities
 - Waste Water Treatment Systems
 - Water Wells
 - Yard Lighting

Buildings

- “Buildings are structures consisting of building shell, exterior walls, interior framings, walls, floors, and ceilings. The asset cost would include a proportionate share of architectural, consulting, and interest expense for newly constructed or renovated facilities.”
 - Boiler House
 - Garage
 - Buildings
 - Brick
 - Block
 - Steel or Wood Frame
 - Concrete Frame
 - Parking Structure
 - Concrete Building
 - Storage Building

Building Components

- “Building components are assets that are part of the building shell or interior construction. The asset cost would include a proportionate share of architectural, consulting, and interest expense.”
 - Canopies
 - Carpentry
 - Caulking
 - Ceiling Finishes
 - Flooring
 - Corner Guards
 - Cubicle Tracks
 - Signs
 - Doors and Frames
 - Drapery Tracks
 - Floor Finishes
 - Millwork
 - Overhead Doors
 - Partitions
 - Railings
 - Skylights
 - Wallcoverings
 - Paint & Wallpaper
 - X-Ray Protection

Building Services Equipment

- “Building services equipment refers to mechanical components or systems designed for the building, including air conditioning, electrical elevators, heating, lighting, plumbing, sprinklers, and ventilating. The asset cost would include a proportionate share of architectural, consulting, and interest expense for newly constructed or renovated facilities”

- Air Conditioning System
- Condenser
- Cooling Tower
- Duct Work
- Piping
- Boiler
- Door Alarm
- Electrical Lighting and Power
- Elevator
- Emergency Generator
- Escalator
- Ceiling Mounted Fans
- Fire Protection
- Furnace
- HVAC
- Heat Pump
- Humidifier
- Insulation
- Magnetic Door Holders
- Nurse Call System
- Plumbing
- Radiator
- Sewerage
- Telephone System
- Temperature Controls
- Water Heater

Other Capital Expenditures - Equipment

- Other capital expenditures typically will not count towards the capital component and would be classified as “equipment” on the capital and cost reports

- Computer Equipment
- Furniture
- Office Equipment
- Bath Tubs
- Beds
- Cabinets (non-built in)
- Chairs
- Chart Racks
- Tables
- Nursing Equipment
- Exercise and Therapy
- Machines
- Scales
- X-ray Machines
- Ovens and Kitchen Equipment
- Floor Buffers
- Vehicles
- Laundry Machines
- Telephone Equipment
- Window Air Conditioners
- Many More

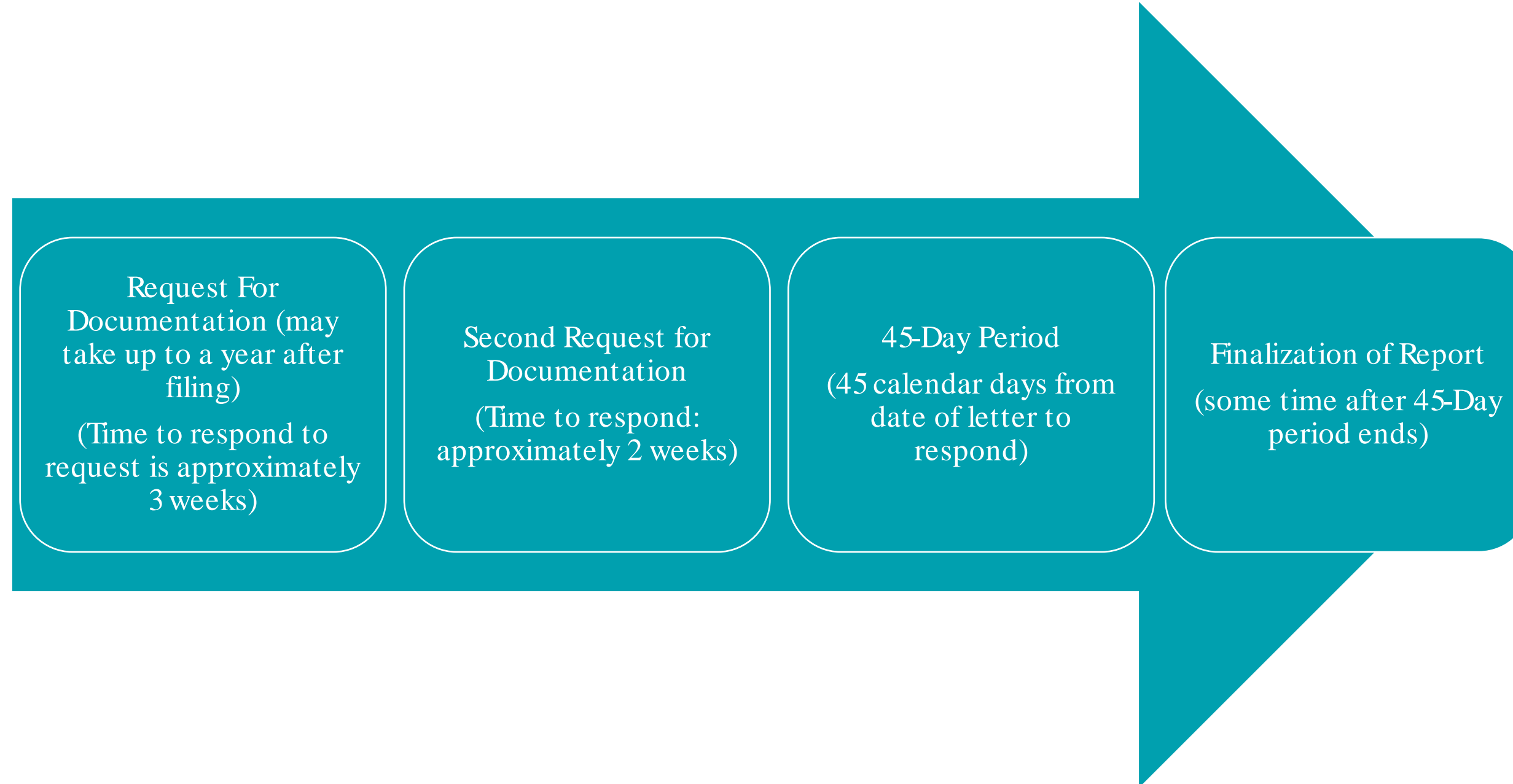
Filing The Capital Report

- As mentioned, all fixed asset expenditures need to be historically reported on the annual cost report
- Classification of assets, cost, year, and descriptions of assets need to be consistent from year to year and any inconsistency could be grounds for disallowance
- Assets must be kept on the cost report until disposal or replacement
- The capital report is a subset of the cost report
- This subset must be filed by June 30th of the year in which a facility wishes to file for the increase, unless the licensed beds increase by 10% or more

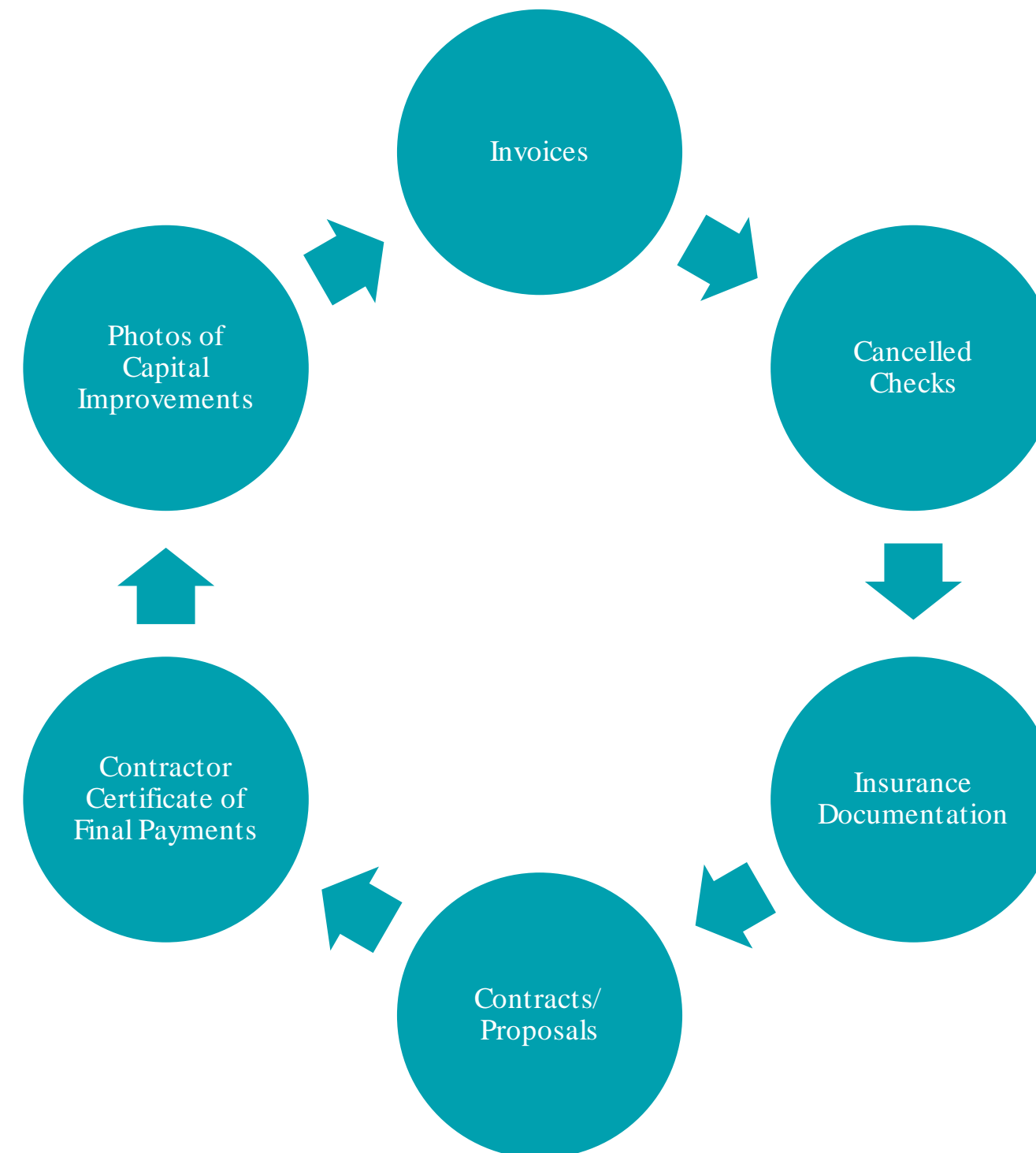
Capital Report Audit Process

- Once submitted, a facility is not guaranteed a capital component rate increase
- Every single capital report that is filed is audited by a representative of HFS
- The aforementioned 10% of historical costs and weighted average year increase criteria must still be met after the report is through the audit with adjustments for a facility to qualify for a capital rate increase

Capital Report Audit Process



Typical Documentation to Support Capital Cost



Finalization of the Capital Report

- After the 45 day period, all remaining adjustments will become permanent
- The auditor will determine if the facility still meets the criteria after making the adjustments
- If criteria are met, the facility will get their full capital rate increase, or a lesser amount if there were adjustments, effective on July 1st of the year in which they filed
- This increase will always be retroactive, no matter how long the capital report process takes
- Please note that having the capital rate increase granted by HFS and receiving payments are two separate functions

Capital Rate Calculation- Example

Basis 7/ 1/22	\$ 4,330,000
Inflator (based on 2016 w/a year)	<u>X 1.0</u>
Inflated value	\$ 4,330,000
Divide by bed size	<u>100</u>
Cost per bed	\$ 43,300
Uniform building value (2016 w/a year)	<u>41,141</u>
Allowable cost per bed	<u>\$ 42,221</u>

Capital Rate Calculation- Example

Allowable cost per bed	\$ 42,221
Divide by 339 days	<u>339</u>
Per diem investment	\$ 124.54
Rate of return (post-1979 w/a year)	<u>11.00%</u>
Capital rate for building	\$ 13.70
Add on for equip., auto, work. cap.	<u>2.50</u>
Preliminary capital rate	\$ 16.20
Real estate tax rate	<u>1.00</u>
Total capital rate prior to % adj.	\$ <u>17.20</u>

Measuring Capital Improvements - Example

- A facility can determine a few measurable outcomes based on their capital improvements and how this affects their bottom line
- Assume a facility just renovated their facility with new flooring, windows, and ceilings throughout the facility
- The total cost of the improvements was \$550,000 and this expenditure put the facility over the 10% amount and increased the weighted average year
- After filing the capital report, their rate increased by \$2.60 per day
- The facility averages 75 Medicaid residents at any given time

Measuring Capital Improvements - Example



Measuring Capital Improvements - Example





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Thank you!