COST REPORTING INSTRUCTIONS for RESIDENTIAL TREATMENT FACILITIES (RTF)

Residential Treatment Facilities are required to file a cost report in accordance with the regulations at 12 VAC 30-80-21. Allowable costs for reimbursement purposes are determined in accordance with Medicare Principles of Reimbursement, including the rules set forth in the Provider Reimbursement Manual, (CMS Pub 15-1). Allowable costs for determining the Residential Treatment Facility Rate do not include costs for drugs and professional (physician) services or patient education/schooling costs. Drugs and professional services must be billed directly to the Medicaid program by the Pharmacy and Physician respectively. Education costs are not covered by Medicaid.

A copy of the cost reporting from RTF-608 can be found on the DMAS Web Site at www.DMAS.Virginia.gov/ in the "Search for Forms" section. Complete the RTF – 608 Cost Reporting Form in accordance with the following instructions and submit with additional documentation per Attachment A – Submission Instructions.

1. Schedule A

a. Record Name, Address, and Provider NPI.
b. Check Type of Facility Certified.
c. Inpatient Statistical Data:
    i. Complete lines 1-8 as indicated.
    ii. In Line 9, report number of FTEs as indicated.
    iii. Report most prevalent semi-private room rate in effect at fiscal year end.
d. Answer Questions 11-13 as indicated.

2. Schedule B (Classification and Adjustment of Expenses)

a. Per the Trial Balance of Expenses, record Salaries and Other Expenses in Columns 1 and 2 and total each line across in Column 3.
b. In Column 4, record the total adjustments (either increases or decreases as applicable) to each Account/Cost Center line as indicated on Schedule B-1.
c. Column 5 is the facility's adjusted expenses (Sum of Column 3 and Column 4).

3. Schedule B-1 (Adjustments to Expenses)

a. This schedule is provided to record adjustments (decreases) for non-reimbursable costs.
b. This schedule is also used to record allowable expenses (increases) not reported on the Trial Balance.
c. The total adjustment amounts should trace to Column 4 of Schedule B for each Account/Cost Center.
d. Either use a standard description line as listed or record an appropriate description on a blank line. **Do not change/overwrite/markout a standard description line** in the Description column. Indicate the basis for the adjustment (A = Expense amount; B = Offset of Income amount). Record the Adjustment amount (increase or decrease). Record the Line Name of the Account/Cost Center to be and then record the appropriate Schedule B Account/Cost Center Line Number.

4. Schedule B-2 (Analysis of Administrative and General – Other)
   a. This schedule provides an analysis/breakdown of the Administrative and General Costs – Other.
   b. The Total A&G costs should trace to Schedule B, Line 1, Column 2.
5. Schedule C (Statement of Services from Related Organizations)
   a. Complete this schedule if the RTF has incurred costs which are a result of transactions with a related organization.
   b. Related organizations are defined in Chapter 10 of the CMS PUB. 15-1 (Provider Reimbursement Manual).

6. Schedule D (Statement of Compensation of Owners) and Schedule E (Statement of Compensation paid to Administrators—other than Owners)
   a. Complete as indicated.
   b. Compensation as used in these schedules is defined in Chapter 9 of the CMS PUB. 15-1

7. Schedule F (Calculation of Residential Treatment Facility Cost Per Day)
   a. This schedule is provided for calculating the Medicaid Program cost per Patient day as well as includes the certification statement to be signed by an official of the Facility.
   b. To be valid, a completed cost report MUST be signed by an authorized officer/administrator of the facility.
   c. Note: Provider rate is limited to the lower of the calculated per diem or ceiling. The per diem is calculated by dividing the lower of costs or charges by Program days.

ATTACHMENT A

COST REPORT SUBMISSION INSTRUCTIONS

Reasonable costs are determined from the filing of a uniform cost report by participating providers. The cost reports are due not later than 150 days after the provider's fiscal year end. If a complete cost report is not timely received, the Program shall take action in accordance with its policies to assure that an overment is not being made. The cost report will be judged complete when DMAS has all of the following:

1. Completed cost reporting form(s) provided by DMAS, with signed certification(s);
2. The provider's trial balance showing adjusting journal entries;
3. The provider's financial statements including, but not limited to, a balance sheet, a statement of income and expenses, a statement of retained earnings (or fund balance), and a statement of changes in financial position
4. Schedules that reconcile financial statements and trial balance to expenses claimed in the cost report;
5. Depreciation schedule or summary;
6. Home office cost report, if applicable; and
7. Such other analytical information or supporting documents requested by DMAS when the cost reporting forms are sent to the provider
8. Copy of cost report submitted to Medicare (if any).

The completed cost report with additional information as described above should be submitted to the DMAS cost settlement and auditing contractor at the following address:

CLIFTON GUNDERSON, LLP
4461 Cox Road, Suite 210
Glen Allen, Virginia 23060

RESIDENTIAL TREATMENT FACILITY (RTF) STATISTICAL AND OTHER DATA

NAME OF RESIDENTIAL TREATMENT FACILITY: _____

ADDRESS: _____

TYPE OF CONTROL

VOLUNTARY NONPROFIT:
1 ____ CHURCH
2 ____ OTHER: PRIVATE

3 _____ PROPRIETARY:
_____ INDIVIDUAL
_____ PARTNERSHIP
_____ CORPORATION
_____ OTHER

GOVERNMENT (NON-FEDERAL):
4 ____ STATE
5 ____ COUNTY
6 ____ CITY
7 ____ CITY-COUNTY
8 ____ HOSPITAL DISTRICT
9 ____ OTHER

TYPE OF FACILITY CERTIFIED

1 ____ ENTIRELY CERTIFIED RESIDENTIAL TREATMENT FACILI
2 _____ RESIDENTIAL TREATMENT FACILITY THAT PROVIDES A LOWER LEVEL OF CARE
3 ____ OTHER:

PERIOD COVERED BY STATEMENT FROM: _____ TO: _____ NPI _____

STATISTICAL DATA

INPATIENT STATISTICS - ALL PATIENTS

COMPLETE COLS 1 AND 2 FOR TYPE OF FACILITY CHECKED

		1, 2, & 3 ABOVE DISTINCT PART OF FACILITY 1	TOTAL FACILITY 2
1	BEDS AVAILABLE AT BEGINNING OF PERIOD		
2	BEDS AVAILABLE AT END OF PERIOD		
3	TOTAL BED DAYS AVAILABLE		
4	TOTAL INPATIENT DAYS		
5	PERCENTAGE OF OCCUPANCY (LINE 4 / LINE 3)		0.00%
6	DISCHARGES, INCLUDING DEATHS		
7	AVERAGE LENGTH OF STAY - INPATIENTS		
8	NUMBER OF ADMISSIONS		

OTHER STATISTICS

		1ST QTR	2ND QTR	3RD QTR	4TH QTR
9	TOTAL NUMBER OF EMPLOYEES ON PAYROLL (FIRST WEEK OF QUARTER)				
	A AVERAGE NUMBER OF FULL TIME EQUIVALENT ON PAYROLL (FIRST WEEK OF QUARTER)				
	B NUMBER OF REGISTERED NURSES (FTE)				
	C NUMBER OF LPNs (FTE)				
	D NUMBER OF AIDES AND OTHER PERSONNEL ASSISTING IN PATIENT CARE (FTE)				

10 MOST PREVALENT SEMI-PRIVATE ROOM RATE IN EFFECT AT FISCAL YEAR END _____

QUESTIONNAIRE

9 HOW WAS DEPRECIATION INCLUDED IN COST STATEMENT CALCULATED?

1 _____ STRAIGHT LINE
2 _____ DECLINING BALANCE
3 _____ SUM-OF-YEARS DIGITS
4 _____ OTHER (SPECIFY)

10 IS DEPRECIATION FUNDED? _____ YES ____ NO BALANCE IN FUND AT END OF PERIOD: _____
IF YES: WHAT BASIS _____

11 WERE THERE ANY GAINS OR LOSSES ON DISPOSALS OF CAPITAL ASSETS DURING PERIOD?
_____ YES ____ NO
INCLUDED IN EXPENSES? _____ YES ____ NO
WHERE? _____

SCHEDULE B

PROVIDER NAME: _____

NPI: _____

FYE: _____

CLASSIFICATION AND ADJUSTMENT OF EXPENSES (Omit Cents)

ACCOUNT	DIRECT EXPENSES PER BOOKS			ADJUSTMENTS TO EXPENSES (SCH B-1)	ADJUSTED EXPENSES (COL 3 + 4)	
	SALARIES 1	OTHER 2	TOTAL (1 + 2) 3	4	5	
ADMINISTRATIVE AND GENERAL						1
INTEREST EXPENSE						2
DEPRECIATION-BUILDINGS, ETC.						3
DEPRECIATION-MOVABLE EQUIPMENT						4
DIETARY - RAW FOOD						5
DIETARY - OTHER EXPENSE						6
HOUSEKEEPING						7
LAUNDRY AND LINEN						8
OPERATION OF PLANT - UTILITIES						9
MAINTENANCE OF PLANT/REPAIRS						10
NURSING SERVICE						11
MEDICAL SUPPLIES AND EXPENSE						12
MEDICAL RECORDS						13
SOCIAL SERVICES						14
OCCUPATIONAL THERAPY						15
SPEECH THERAPY						16
PHYSICAL THERAPY						17
OTHER THERAPY						18
PATIENT ACTIVITIES PROGRAM						19
						20
						21
						22
TOTAL ALLOWABLE RTF FACILITY COSTS						23
NON-ALLOWED RTF COSTS:						24
EDUCATION/SCHOOL						25
PHARMACY/DRUGS						26
PROFESSIONAL FEES (PHYSICIANS)						27
						28
						29
						30
TOTAL EXPENSES						31

FORWARD TO
SCHEDULE F, LINE 4

SCHEDULE B-1

PROVIDER NAME: _____

NPI: _____

FYE: _____

ADJUSTMENT TO EXPENSES (Omit Cents)

	DESCRIPTION	BASIS FOR ADJUSTMENT*	(1) AMOUNT INCREASE AND (DECREASES)	(2) SCHEDULE B EXPENSE CLASSIFICATION	(3) COL 4 LINE #
1	Telephone Service (Pay Stations Excluded)			Admin & General	1
2	Radio and Television Service			Admin & General	1
3	Vending Machines Commission			Operation of Plant	9
4	Employee and Guest Meals			Dietary - Raw Food	5
5	Sale of Scrap, Waste, etc.			Maintenance of Plant	10
6	Rental of Quarters to Employees and Others			Admin & General	1
7	Rental of Facility Space				
8	Rebates and Refunds of Expenses				
9	Trade, Quantity, Time and Other Discounts on Purchases				
10	Interest on Unrestricted Funds				
11	Grants, Gifts, and Income designated by the Donor for Specific Expenses				
12	Bad Debts	A		Admin & General	1
13	Fund Raising Expenses				
14	Depreciation			Depreciation-Buildings	3
15	Depreciation			Depreciation-Movable Equip	4
16	Pharmacy			Med Supplies & Exp	12
17	Occupational Therapy			Occupational Therapy	15
18	Speech Therapy			Speech Therapy	16
19	Physical Therapy			Physical Therapy	17
20	Other Therapy			Other Therapy	18
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					
32					
33					
34					
35					
36					
37					
38					
39					
40					
41					
42					
43					
44					
45					
46					
47					
48					
49					
50					
51					
52					
53					
54	**TOTAL**				

***** **Basis for Adjustment:** **A = Cost/Expense (if known)** **B = Amount Received if cost/expense is not known (This would be an offset of income)**

SCHEDULE B-2

PROVIDER NAME: _____

PROVIDER NUMBER: _____

FYE: _____

ANALYSIS OF ADMINISTRATIVE AND GENERAL - OTHER (Omit Cents)

	EXPENSE CLASSIFICATION	AMOUNT
1	Advertising	
2	Telephone	
3	Dues & Subscriptions	
4	Equipment Rental	
5	Office Supplies	
6	Printing & Postage	
7	Other (Specify)	
8	Purchased Services	
9	Travel	
10	Auto	
11	Public Relations	
12	Taxes & Licenses	
13	Insurance	
14	Payroll Taxes / Employee Benefits	
15	Consultants (Specify)	
a		
b		
c		
d		
16	Non-Allowables: (Specify & post individually to Schedule B-1)	
a	BAD DEBTS	
b		
c		
d		
	Total Administrative & General Cost (To Schedule B, Line 1, Col 2)	

SCHEDULE C

PROVIDER NAME: _____

NPI: _____

FYE: _____

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

A IN THE AMOUNT OF COSTS TO BE REIMBURSED BY THE HEALTH INSURANCE PROGRAM, ARE ANY COSTS INCLUDED WHICH ARE A RESULT OF TRANSACTIONS WITH A RELATED ORGANIZATION AS DEFINED IN CHAPTER 10 OF CMS PUB. 15-1?

____ YES ____ NO (IF "YES", COMPLETE PART B, AND SUBMIT SCHEDULE ITEMIZING TOTAL EXPENSES AND BASIS OF ALLOCATION)

B COSTS INCURRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS (Omit Cents)

FORM NO	LINE NO	ITEM	AMOUNT
B			
B-2			
B-2			

C NAME AND PERCENT OF OWNERSHIP IN THE RELATED ORGANIZATIONS

NAME OF OWNER	NAME OF RELATED ORGANIZATION	% OWNERSHIP

SCHEDULE D

PROVIDER NAME: _____

NPI: _____

FYE: _____

STATEMENT OF COMPENSATION OF OWNERS (Omit Cents)

		SOLE PROPRIETOR	PARTNERS		CORPORATE OFFICERS		
NAME	TITLE & FUNCTION	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	% SHARE OPERATING PROFIT OR (LOSS)	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	% OF PROVIDER'S STOCK OWNED	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	COMPLETE INCLUSIVE ALLOWABLE COSTS FOR PERIOD
(1)	(2)	(3)	(4a)	(4b)	(5a)	(5b)	(6)

SCHEDULE E

PROVIDER NAME: _____

NPI: _____

FYE: _____

STATEMENT OF COMPENSATION PAID TO ADMINISTRATORS
AND/OR ASSISTANT ADMINISTRATORS (OTHER THAN OWNERS) [Omit Cents]

NAME	TITLE & FUNCTION	% OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	COMPENSATION FOR THE PERIOD
	TOTAL:	0%	

SCHEDULE F

PROVIDER NAME: _____

NPI: _____

FYE: _____

CALCULATION OF RESIDENTIAL TREATMENT FACILITY COST PER DAY (Omit Cents)
FOR THE COST REPORTING YEAR

1	TOTAL PATIENT DAYS (FROM RTF-608, SCHEDULE A, COLUMN 2, LINE 4)	
2	TOTAL RTF MEDICAID PROGRAM PATIENT DAYS (FROM PROVIDER'S RECORDS)	
3	PERCENT OF RTF PROGRAM PATIENT DAYS TO TOTAL DAYS (LINE 2 / LINE 1)	0.00%
4	TOTAL RTF FACILITY COSTS (FROM RTF-608, SCHEDULE B, LINE 31)	
5	LESS NON-ALLOWABLE RTF FACILITY COSTS (SCHEDULE B - SUM OF LINES 24 - 30)	
6	LESS PLANT COSTS (SCHEDULE B - SUM OF LINES 2 - 4)	
7	OPERATING COSTS (LINE 4 MINUS LIINES 5 AND 6)	
8	PROGRAM OPERATING COST (LINE 3 x LINE 7)	
9	PROGRAM OPERATING COST PER DAY (LINE 8 / LINE 2)	#DIV/0!
10	PROGRAM PLANT COST (LINE 3 x LINE 6)	
11	PROGRAM PLANT COST PER DAY (LINE 10 / LINE 2)	#DIV/0!
11	PROGRAM RTF FACILITY COST PER DAY (LINE 8 + LINE 10)	#DIV/0!

INTENTIONAL MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Statement of Reimbursable Cost and the Statements of Financial Position, Activities and Cash Flows prepared by:

_____ for the cost report period beginning _____ and ending _____ , and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signed)

_____
Officer or Administrator of Provider

_____
Title

_____
Date