THE STATE OF SOUTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
INSTRUCTIONS FOR PREPORATION OF
FINANCIAL & STATISTICAL REPORTS
FOR COMMUNITY LONG TERM CARE SERVICES

GENERAL COMMENTS:

The accompanying reporting form is required from Community Long Term Care (CLTC) Providers on both a prospective and a historical basis in order to develop a statistical and actual cost data base for Adult Day Health Care Services (ADHC), Adult Day Health Care Nursing Services (ADHCN), Personal Care I Services (PCI), Personal Care II Services (PCII), and Medicaid Nursing Services (MN). Information submitted on these reports may be used in determining future reimbursement rates. At the top of each page of the report, indicate the provider's name and the fiscal period covered by the report being submitted. If you have multiple sites that provide the same service(s), the report may be completed as a compilation of the actual costs and statistical data for all sites. Or, the report may be completed specific for a given site. Provide a narrative explanation of all "miscellaneous" or "other" expenses incurred for each service; and when costs are allocated between two or more services, include a narrative explanation of the basis of the allocations. You should retain documentation, which supports the allocations. The Financial and Statistical Reports (hereafter referred to as "The Cost Report"), as well as support documentation, are subject to audit by the South Carolina Department of Health and Human Services (hereinafter referred to as the "SCDHHS") or by its designee.

Pages 1, 2 and 3 contain provider identifying information, as well as ownership information. Information regarding the completion of the report is also included on page 1. Page 4 should identify all sources on income used by the provider for the provision of these services being reported. The lower portion of this page indicates the number of clients served and units provided for each service. All direct costs that are identified as administrative costs associated with providing each service should be included on page 5. The listing of possible expense items included on this page is not intended to be all-inclusive. All costs, which are associated with the actual provision of services, should be indicated in the appropriate sections of pages 6, 7 and 8. Page 9 identifies any loan payments and asset additions made in support of the service(s) being reported during the time period covered by the report. **Page 10 is a Personnel Schedule and must be completed in its entirety or the report will not be accepted by the SCDHHS.** Page 11 is a summary page that gives a snapshot of the CLTC provider's fiscal period being reported. The original and one copy of each completed report should be mailed to: **Division of Ancillary Reimbursements, SC Department of Health and Human Services, P.O. Box 8206, Columbia, SC 29202-8206.** Or, it may be hand delivered to the **Division of Ancillary Reimbursements, SCDHHS, 1813 Main Street, Suite 137, Columbia, SC 29201.**

Failure to submit this report, within the requested time frame, may result in the withholding or suspension of your reimbursements.

Attached is a listing of account descriptions for income/revenue as well as for expenses. This listing is not all-inclusive and is for example purposes only. However, the descriptions should be of assistance as you prepare your narrative explanations required to accompany your report.

While much of the report is self-explanatory, each page of the report will be addressed to assist you in preparing the report. If further assistance is needed, please contact Division of Ancillary Reimbursements at the SCDHHS at **(803) 898-1040.** Or, you may fax questions to **(803) 255-8228.**

Page 1 of 11 Pages:

Item 1: (a) Indicate the Provider's name, actual street address, mailing address, telephone number and fax number in the appropriate spaces provided. If additional space is needed, attach additional pages as may be necessary. Immediately following the Provider's name is a space indicated for "EIN#". The EIN # stands for the Provider's Employer Identification Number. Enter the federal employer identification number assigned by the Internal Revenue Service.

Item 1: (b) Indicate the control type or legal status of the provider agency by marking the appropriate space.

Item 2: Indicate the name of the director of the agency.

Item 3: If your agency utilizes an accounting firm for any purpose, such as auditing, payroll, bookkeeping, etc., indicate the name, address and telephone number in the appropriate spaces.

Item 4: Indicate the name, title, address and telephone number of the person who actually prepared this report. If an accounting firm was utilized, indicate the actual employee of the accounting firm that prepared the report.

Item 5: The owner or director of the provider agency **and** the person who actually prepared the report need to sign and date the certification statement in the appropriate place. **If a report is not signed and dated by both, the report will not be accepted by the SCDHHS.**

Page 2 of 11 Pages:

Item 6: The name, address and telephone number of the actual owner(s) of a private for profit agency need to be indicated in the appropriate space. If there are multiple owners, attach the requested information for each owner. For a non-profit agency, the requested information should be provided for all board members. For public providers, the requested information should be provided for the administrator as well as board members, if applicable.

Item 7: This section reflects owner(s) compensation. Enter the owner(s)'s full name and the appropriate job title, e.g. director, bookkeeper, nurse supervisor, personal care aide, etc. in the applicable column.

Page 2 of 11 Pages (continued):

Item 7 (continued): Enter the total hours actually worked during the reporting period. Include all hours, whether allowable or not, if paid as a part of the service. Allowable compensation will be based on 40 hours per week (2080 hours annually). **If hours are not reported, then salary and fringe benefits associated with the salary will be considered as non-allowable.** Enter the amount of any type of compensation, such as salary, bonus, consultant fees, etc. Include any other form(s) of compensation such as personal auto allowances/expenses, meals, etc. Both allowable and non-allowable compensation should be shown in this section. Indicate the page number and line number where the costs are included in the related section(s). If compensation was made for this person at another facility or in another program operated by the provider, then "YES" should be indicated in this column. If not, then "NO" should be indicated. There should be a "YES" or "NO" indication for each person listed. If "YES", indicate the facility or program from which this person has received compensation. Attach additional narrative as may be necessary.

Item 8: This section reflects relative(s) compensation. Complete this section for all persons related by blood or marriage. For detailed instructions, refer to Item 7. Complete Item 8 in a similar manner as Item 7.

Page 3 of 11 Pages:

Item 9: Indicate what CTLC services are provided by your agency. Check all of the services that may be applicable. If there are other services that you provide as part of your Community Long Term Care contract for which you receive payment from SCDHHS, specify the service(s) name(s) in the appropriate space. If additional room is necessary, please attach additional pages as may be required. Indicate your Medicaid Provider Number for each service listed.

Item 10: This section reflects transactions with a related party or with another business owned by the owner. If no related business is done, then check "NO". But if business is conducted with a related entity, check "YES" and complete the rest of Item 10 as follows:

Column 1: Enter the name of the related organization(s).
Column 2: Indicate the item involved in the transaction.
Column 3: Enter the amount resulting from the described transaction with a related organization, which was charged to the CLTC provider.
Column 4: Enter the actual cost to the related organization of acquiring or producing the goods or services supplied to the provider for which the reported expenses were entered in the preceding column.
Column 5: Enter the page and line where the costs were included in the financial report.

Page 4 of 11 Pages:

Page 4 is used to indicate all income received by the provider that was used, or available for use, for the provision of CLTC services. Lines 1 through 6 indicate specific categories of income.

Page 4 of 11 (continued):

If you received income from other sources for these services, indicate the amount on line 7. In the "Total Income" column to the right of the designated sources of income, indicate the total income from that specific source for all services. If additional space is needed to list other sources of income and amounts, use the notes at the bottom of Page 4. If necessary, use additional pages as may be appropriate. Line 8 should be the total of all income received from all sources for the CLTC services. If CLTC services are indicated on page 3, Item 9, all revenue received for these services should be identified, by service, on page 4.

The bottom portion of Page 4 is to indicate the number of clients served and the number of units provided in the CLTC program. On Line 9, indicate the total number of clients that received services through your agency, regardless of the client's status or funding source. This would include Medicaid clients as well as private pay or any other clients. On Line 10, indicate only the number of Medicaid clients. On Line 11, show the total number of units of service, which were provided by your agency, regardless of funding source. On Line 12, show only the units of service that were provided to Medicaid clients. Include client and unit information in any of the columns that specify services provided by your agency.

Page 5 of 11 Pages:

Page 5 is to be used to report administrative expenses only. If you have other administrative expenses indicated on Line 17, or other employees benefits and fringes for administrative staff indicated on Line 23, indicate what those expenses were and the amount spent for each service in the "NOTES" section at the bottom of the page. You may also use Line 19 to indicate other administrative expenses, which have been incurred by your agency in the provision of CLTC services. You should show the total administrative expenses on Line 24. Total each column for each service your agency provides.

Page 6 of 11 Pages:

Page 6 is to show direct service expenses for staff and other expenses as may be necessary and appropriate in the delivery of CLTC services. Include expenses in each column as incurred for each specific service. If you have other expenses indicated on Line 14 or other employee benefits and fringes indicated on Line 18, you must provide a detailed explanation of each expense and the amount of each expense that are included on Line 14 or Line 18. You should show the total direct service cost on Line 19. Total each column for each service your agency provides.

Page 7 of 11 Pages:

The upper portion of Page 7 is to reflect the expenses of utilities (Lines 1 through Line 7). If you show other utilities expenses on Line 6, include a narrative explanation and amount for each expense in the "NOTES" section at the bottom of the page. Line 7 should show the total expenses for all utilities. Total each column for each service your agency provides.

Page 7 of 11 Pages (continued):

The lower portion of Page 7 is to show the expenses for taxes, insurance and licenses (Lines 8 through 15). If you show other expenses for taxes, insurance and/or licenses on Line 14, include a narrative explanation and amount for each expense in the "NOTES" section at the bottom of the page. Line 15 should show the total expenses for all taxes, insurance and licenses. Total each column for each service your agency provides.

Page 8 of 11 Pages:

Cost of Capital:

Lines 1, 2 and 3 indicate the amount to be charged for depreciation for land improvements, building(s) and equipment/furniture. Lines 4 and 5 are used to report rental expenses for building(s) and equipment/furniture. Lines 6 and 7 are used to report expenses for interest related to building(s) and equipment/furniture. If you have other interest indicated on Line 8, you must include a detailed explanation of what this interest is and the amount in the "NOTES" section at the bottom of the page. Line 9 should show the total expenses for the Total Cost of Capital. Total each column for each service your agency provides.

Nonallowable:

Lines 10 through 16 list some of the types of expenses that are not allowable for Medicaid reimbursement. If you have other expenses, which are not allowable for Medicaid reimbursement, those expenses should be indicated on Line 17. If you do have expense indicated on Line 17, you must provide a detailed narrative explanation in the "NOTES" section at the bottom of the page. The items listed on Lines 10 through 16 are not all-inclusive of non-allowable costs for Medicaid reimbursement. Line 18 should indicate all non-allowable Medicaid expenses. Total each column for each service your agency provides.

Page 9 of 11 Pages:

Debt Schedule:

The upper portion of Page 9 is provided to disclose any mortgage payments or payment on any notes payable. Complete this section if you are paying a mortgage or have other notes payable during the reporting period, i.e., loans for vehicles, equipment, working capital, etc.

Asset Addition Schedule:

The lower portion of Page 9 is provided to disclose assets acquired during the reporting period. Please complete this section if you made any asset acquisitions during reporting period.

Page 10 of 11 Pages:

Page 10 is referred to as the "Personnel Schedule". This schedule must be completed in full. **If the Personnel Schedule is not completed in full, then your report will not be accepted by the SCDHHS.**

Page 10 of 11 Pages (continued):

Column 1: Indicate the title of each position that was paid in whole or in part for CLTC services provided during the reporting period. If there are several employees who occupy a position of the same title, indicate the number of employees beside the name of the respective title(s).

Column 2: Indicate the total number of hours worked by all employees for each position title listed that was paid, in whole or in part, for the service being reported during the reporting period.

Column 3: Indicate the hourly wages paid to each position title. This may be an average if several employees occupied this type of position.

Column 4: Indicate the salary and wages, exclusive of any fringe benefits or employer contributions, for each type of position.

Column 5: Indicate the dollar amount of the expenditures for each position that is allocated to administrative efforts for the service being reported.

Column 6: Indicate the dollar amount of the expenditures for each position that is allocated to the direct ADHC services cost for the service being reported.

Column 7: Indicate the dollar amount of the expenditures for each position that is allocated to the direct ADHCN services cost for the service being reported.

Column 8: Indicate the dollar amount of expenditures for each position that is allocated to the direct PC-I services cost for the service being reported.

Column 9: Indicate the dollar amount of expenditures for each position that is allocated to the direct PC-II services cost for the service being reported.

Column 10: Indicate the dollar amount of the expenditures for each position that is allocated to the direct MN services costs for the service being reported.

Column 11: Indicate the dollar amount of the expenditures for each position that is allocated to other efforts during the reported period.

The total of columns 5,6,7,8, 9 10, and 11 should equal the amount indicated in Column 4.

Note: If any personnel are hired on a contracted basis, identify and list those positions separately **after** direct agency personnel. Separately subtotal direct agency and contracted positions' hours and salary data. The grand total should include all direct agency personnel and contracted personnel.

Page 11 of 11 Pages:

Page 11 is a summary of income, expenses and units provided by the CLTC provider. **The amounts of income listed for each service on Line 1 should correspond with the total of income on Line 8 of Page 4.**

The amounts listed for expenses should correlate as follows:

-Administrative expenses on Line 24 of Page 5
-Direct Services expenses on Line 19 of Page 6
-Utilities on Line 7 of Page 7
-Taxes, Insurance and Licenses on Line 15 of Page 7
-Cost of Capital on Line 9 of Page 8
-Non-Allowable expenses on Line 18 of Page 8

The "NET SURPLUS or (LOSS)" indicated on Line 9 of Page 11 should equal Line 1 on Page 11 **minus** Line 8 on Page 11. If the result is a positive number, then your program has experienced a **Surplus.** If the result is a negative number, then your program has experienced a **Loss.** Your agency may experience a surplus in one service area and a loss in another service area.

The total units of service(s) provided as stated on Line 10 of Page 11 should correspond to total units of service for each service on Line 11 of Page 4.

If you need additional assistance in completing this report, contact the Division of Ancillary Reimbursements at the SCDHHS. Our phone number is (803) 898-1040 and our Fax number is (803) 255-8228. The Division of Ancillary Reimbursements is located at 1813 Main Street, Suite 137, Columbia, South Carolina 29201.