State of California
Office of Administrative Law

In re: **Department of Health Care Access and Information**	**NOTICE OF APPROVAL OF REGULATORY ACTION**
Regulatory Action:	**Government Code Section 11349.3**
Title 22, California Code of Regulations	**OAL Matter Number: 2023-0906-01**
Adopt sections: **Amend sections: 97019, 97041** **Repeal sections:**	**OAL Matter Type: Regular (S)**

In this rulemaking action, the Department amends its regulations to update two documents incorporated by reference: the Accounting and Reporting Manual for California Long-Term Care Facilities, Second Edition (LTC Manual), and the Instructions and Specifications for Developing Approved Software to Prepare the California Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report (LTC Report). The amendments update the agency's name in the documents, revises reporting procedures and software specifications, and expand the number of payer categories.

OAL approves this regulatory action pursuant to section 11349.3 of the Government Code. This regulatory action becomes effective on 1/1/2024.

Date: October 18, 2023

Thanh Huynh
Senior Attorney

For: Kenneth J. Pogue
Director

Original: Elizabeth Landsberg, Director
Copy: Lexie Bloyd

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATION SUBMISSION

REGULAR

STD. 400 (REV. 10/2019)

For use by Secretary of State only

OAL FILE NUMBERS	NOTICE FILE NUMBER	REGULATORY ACTION NUMBER	EMERGENCY NUMBER
	Z- 2023-0530-03	2023-0906-01	S

For use by Office of Administrative Law (OAL) only

OFFICE OF ADMINISTRATIVE LAW

Electronic Submission

RECEIVED DATE	PUBLICATION DATE
05/30/2023	06/09/2023

NOTICE

OFFICE OF ADMIN. LAW
2023 SEP 6 PM2:40

REGULATIONS

ENDORSED - FILED
in the office of the Secretary of State
of the State of California

OCT 18 2023
3:08 PM

AGENCY WITH RULEMAKING AUTHORITY
Health Care Access and Information

AGENCY FILE NUMBER (If any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
LTC Financial - Expand Managed Care	22	97019	June 9 , 2023

3. NOTICE TYPE	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
[X] Notice re Proposed Regulatory Action [ ] Other	Lexie Bloyd	916-326-3833	

OAL USE ONLY	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE
	[ ] Approved as Submitted [ ] Approved as Modified [ ] Disapproved/ Withdrawn	2023, 23-Z	6/9/23

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S)	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
LTC Financial Reporting - Expanding Managed Care	

2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) **(Including title 26, if toxics related)**

SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	
TITLE(S) 22	ADOPT
	AMEND SECTIONS 97019, 97041
	REPEAL

3. TYPE OF FILING

- [X] Regular Rulemaking (Gov. Code §11346)
- [ ] Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §§11346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.
- [ ] Emergency Readopt (Gov. Code, §11346.1(h))
- [ ] Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
- [ ] Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §§11349.3, 11349.4)
- [ ] File & Print
- [ ] Print Only
- [ ] Emergency (Gov. Code, §11346.1(b))
- [ ] Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)
- [ ] Other (Specify) _____

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)

- [X] Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))
- [ ] Effective on filing with Secretary of State
- [ ] §100 Changes Without Regulatory Effect
- [ ] Effective other (Specify) _____

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY

- [X] Department of Finance (Form STD. 399) (SAM §6660)
- [ ] Fair Political Practices Commission
- [ ] State Fire Marshal
- [ ] Other (Specify) _____

7. CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional)
Lexie Bloyd	(916) 326-3833		Lexie.Bloyd@hcai.ca.gov

8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE	DATE
J Scott Christman	8/29/2023

TYPED NAME AND TITLE OF SIGNATORY
J Scott Christman, Chief Deputy Director, for Elizabeth Landsberg

For use by Office of Administrative Law (OAL) only

ENDORSED APPROVED

OCT 18 2023

Office of Administrative Law

HCAi Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833
hcai.ca.gov

Proposed Amendments to Regulations

CALIFORNIA CODE OF REGULATIONS

Title 22, Division 7, Chapter 10: Health Facility Data – Expanding Managed Care Payer Categories

Sections 97019 and 97041

§ 97019 Accounting and Reporting Manual for California Long Term Care Facilities.

(a) To assure uniformity of accounting and reporting procedures among long-term care facilities, the Office shall publish an "Accounting and Reporting Manual for California Long-term Care Facilities", which will be supplemental to the system adopted by this chapter. The "Accounting and Reporting Manual for California Long-term Care Facilities", Second Edition (Manual) as amended ~~April 1, 2020~~ *October 2023*, shall not be published in full in the California Code of Regulations, but is hereby incorporated by reference. For report periods ending prior to January 1, 202~~4~~0, facilities must use the version of the Manual as amended ~~October 1, 2019~~ *April 1, 2020*. For report periods ending on or after January 1, 202~~4~~0, facilities must use the "Accounting and Reporting Manual for California Long-term Care Facilities," Second Edition (Manual) as amended *October 2023*~~April 1, 2020~~, which is hereby incorporated by reference. All long-term care facilities must comply with the systems and procedures detailed in the applicable version of the Manual. Copies of the Manual may be obtained from the Office at 2020 West El Camino Avenue, Suite 1100, Sacramento, CA 95833, or by downloading from the OSHPD website. The Office shall provide each new long-term care facility with a copy of the ~~"Accounting and Reporting~~ Manual ~~for California Long-term Care Facilities"~~. The Manual published by the Office shall be the official and binding interpretations of accounting and reporting treatment within the long-term care facility accounting and reporting system.

(b) Requests for modifications to the accounting and reporting systems as set forth in the Manual shall be filed as provided under Section 97050.

Authority: Section 128810, Health and Safety Code; Reference: Section 128760, Health and Safety Code.

§ 97041. Report Procedures

(a) Health facilities shall report to the Office as follows:

(1) Health facilities shall prepare annual disclosure reports required by subsections (a) through (e) of Section 128735, Health and Safety Code, in a standard electronic format as approved by the Office pursuant to subsection (3) and file annual disclosure reports with the Office pursuant to subsection (4). Health facilities may file requests for modifications to this reporting requirement, as provided under Section 97050, where meeting this requirement would not be cost-effective for the facility.

(2) To meet the requirement of subsection (1), health facilities shall use a program approved pursuant to subsection (3), which can be either a third-party program or their own program. Health facilities intending to use a third-party program are not required to notify the Office of that intent. The Office shall notify all health facilities and third-parties with Office-approved electronic reporting programs of any change in the electronic reporting requirements. The Office shall maintain and make available a list of all programs approved pursuant to subsection (3).

Programs to be used for preparing reports in a standard electronic format pursuant to subsection (1) must be approved by the Office in advance and must meet the Office's specifications for electronic reporting. To be approved, electronic report preparation programs must be able to apply Office-specified edits to the data being reported and must be able to produce a standardized output file that meets the Office's specified electronic formats. Specifications for preparing hospital annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements, as published by the Office in the May 2019 issue of "Instructions and Specifications for Developing Approved Software to Prepare the California Hospital Annual Disclosure Report," and herein incorporated by reference in its entirety. For report periods ending prior to January 1, 20204~~0~~, specifications for preparing the LTC facility annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements, as published by the Office in *the October 2019 issue of*~~the May 2019 issue of~~ "Instructions and Specifications for Developing Approved Software to Prepare the Californian Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report", and herein incorporated by reference in its entirety. For report periods ending on or after January 1, 20240, specifications for preparing LTC facility annual reports in a standard electronic format shall be provided by the Office upon request and shall include file and record formats, editing criteria, and test case requirements, as published by the Office in the ~~October 2019~~ *October 2023* issue of "Instructions and Specifications for Developing Approved Software to Prepare the California Long-Term Care Facility Integrated Disclosure & Medi-Cal Cost Report," and incorporated by reference in its entirety. To obtain approval for an electronic report preparation program, a request, together with the Office's specified test case and a signed statement certifying that the program includes all Office-specified edits, must be filed with the Office *via email to financial@hcai.ca.gov.* ~~at 2020 West El Camino Avenue, Suite 1100, Sacramento, CA 95833~~, at least 90 days prior to the end of the reporting period to which the program applies. The Office shall review the test case and respond within 60 days by either approving or disapproving the request. The Office may limit the approval of the electronic report preparation program to a specified period of time or reporting period(s). If disapproved, the Office shall set forth the basis for a denial. The Office may seek additional information from the requestor in evaluating the request. Changes to the Office's electronic reporting specifications may require the programs used for preparing reports in a standard electronic format to be re-approved.

(3) Health facilities must file annual disclosure reports with the Office using SIERA.

(4) Hospitals shall prepare and file the quarterly reports required by Section 128740, Health and Safety Code, with the Office using SIERA. Hospitals may file requests for modifications to this reporting requirement, as set forth under Section 97050, where meeting this requirement would not be cost-effective for the hospital.

(b) Health facilities shall use SIERA to revise reports that have been filed with the Office according to (a) of this Section.

(c) Congregate living health facilities are exempt from the electronic reporting requirements of (a) and (b) of this Section. Congregate living health facilities may file annual disclosure reports using SIERA or using hard-copy report forms.

Note: Authority cited: Section 128810, Health and Safety Code. Reference: Sections 128680, 128730, 128735, 128740, and 128755 Health and Safety Code.

Proposed amendments to the *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition:

Proposed amendments begin on the next page and are formatted with red strikeout and blue italics.

(TH) 10/13/2023 per agency request

CHAPTER 1000 – Accounting Principles and Concepts

AMORTIZATION

1030
(Rev. October 2023)

Often it is necessary for a facility to purchase goods or services in bulk quantities or amounts that will be used over more than one accounting period. In such cases it is necessary to spread the cost of the goods or services over the several accounting periods in which used. This process of spreading is known as amortization. For example, suppose a long-term care facility purchased a fire insurance policy on its building covering three years. The policy is purchased for $300 on January 1, 19Xl and covers all of 19Xl, 19X2 and 19X3. Proper treatment of this purchase would require the assignment of $100 ($300) 3 years) to each of the three years as insurance expense.

The initial entry to record this policy would be:

Jan. 1	Dr.	1101	Prepaid Insurance	$300	
	Cr.	1001	Cash		$300

The policy is recorded as an asset and not as an expense at this time because it represents a service that has been paid for in advance which has not been provided. At the end of 19Xl, one year's worth of this service has been used and must be matched with revenues produced during the period by reducing the asset by $100 and recording insurance expense of $100.

Dec. 31	Dr.	7400.90	Property Insurance	$100	
	Cr.	1101	Prepaid Insurance		$100

Similar entries would be made at the end of 19X2 and 19X3. The facility may choose to make these entries on a monthly basis in order to provide itself with a more timely and continuous record of expenses. In this case the monthly charge to insurance expense and credit to prepaid insurance would be one-twelfth of the annual amount or $8.33.

The most common type of amortization that a long-term care facility will use involves the spreading of the cost of a physical asset such as an automobile, piece of equipment, or leasehold improvements over its estimated useful life. Amortization, when applied to such an asset, is most commonly referred to by the term depreciation. For example, a leasehold improvement erected at a cost of $20,000 and having a life of forty years would be recorded as an asset in the period of its completion. Each year, $500 ($20,000) / 40 years) of its original cost would be charged to depreciation expense. Note: In this example, the estimated life remaining on the original lease is greater than 40 years.

There is a problem, however, in applying depreciation to a physical asset, since its exact life span is rarely known in advance. This inability to determine exactly a fact that is necessary to properly match revenues and expenses generally will not allow the rules of accrual accounting to be ignored. In such cases, it is required that an estimate of the necessary facts be made and that this estimate be used in allocating the cost of the asset to future periods' revenues. As better information becomes available in the future, the estimate should be revised to more accurately assign the remaining cost of the asset to the remaining part of its useful life. A more complete discussion of the subject of depreciation is presented later in this chapter.

TH 10/18/2023 per agency request

DEDUCTIONS FROM REVENUE

1060

CONTRACTUAL ADJUSTMENTS

1061
(Rev. October 2023)

In general, each facility will have established standard rates that are charged for various types of services. However, in many cases, the full amount of the charge is not actually collected due to contracts with third-party payors which specify lower rates, or for other reasons. A facility must record revenues from providing patient care to persons under third-party contractual agreements at its full established rates and also record a contractual adjustment. In such instances, contractual adjustments is the term representing deductions from revenue recorded for the difference between the amount of patient charges (based on full established rates) for services which are rendered during a reporting period and are covered by a third-party contract, and the amount received or to be received from third-party payors in payment of such charges.

There are basically four types of transactions which can result in a contractual adjustment. Two are discussed below, and two are discussed under the caption "Accounting for Managed Care and Other Contracts," which follows.

1. Medicare Interim Reimbursement Rate (MIRR) - For interim cost reimbursement purposes, the Medicare intermediary will pay to the facility a per diem interim reimbursement which is based on an estimate of allowable costs plus, in some instances, a small return on equity. There is normally a difference between recorded gross charges and the interim reimbursement for the corresponding items of patient service. This difference is recorded as an adjustment to revenue. Since MIRR is only an estimate of allowable cost plus return on equity, there is an adjustment to the contractual adjustment account required at year-end based upon an estimate of final reimbursement, and when cost reports are prepared and filed.

2. Periodic Interim Payments (PIP) - These payments from the Medicare program are made on a regular basis to a facility on the PIP program. They are based on an estimate of the allowable costs (plus, in some instances, a small return on equity) applicable to covered patient charges for the current cost report period. When such payments are received, the Cash (Account 1001) is debited and Accounts Receivable - Medicare (1021), is credited. When applicable Medicare charges are

earned, Account 1021 is debited and the appropriate revenue account is credited.

At year end, several adjustments are necessary to properly reflect the amount receivable from (Account 1051), or due to (Account 2051), the Medicare intermediary. First, all Medicare charges in Account 1021 (net of deductibles, coinsurance, and PIP payments) at year end must be transferred to Account 5310, Contractual Adjustments - Medicare.

If there is an amount due to Medicare -

Dr. 5310 Contractual Adjustments - Medicare

Cr. 2050 Payable to Third-Party Payors

If there is an amount receivable from Medicare -

Dr. 1050 Receivables from Third-Party Payors

Cr. 5310 Contractual Adjustments - Medicare

Separate contractual adjustment accounts are provided for the Medicare program, the Medi-Cal program, and for other programs. It is suggested that separate subaccounts be kept for each year for which cost or other similar reports are not yet finalized by the intermediary. *It is further suggested that separate subaccounts be kept to differentiate fee-for-service contractual adjustments from managed care contractual adjustments. For more information on this topic, see Section 4020.5.*

To provide accurate interim financial data, it is recommended that each facility adjust its contractual adjustment accounts based on the above procedures and estimated cost report determinations at each month end.

The Medicare program limits reimbursement in each year to the lower of reimbursable costs or charges. Amounts of reimbursable costs in excess of this limitation may be carried forward, in accordance with Medicare regulations, for potential reimbursement in subsequent years. The benefit of such carry-forward amounts should not be recognized in the year in which it arises since reimbursement for the carry-forward is not assured. Rather, such benefit should be recognized in the contractual adjustment account in the subsequent year in which the carry-forward becomes reimbursable.

There may be a difference each year between the cost report filed by the facility and the final settlement received from the third party payor. These differences should not be treated as prior period adjustments unless they meet the criteria set forth in Financial Accounting Standards Board Statement No. 16, "Prior Period Adjustments", or are deemed to result from an error as indicated in Accounting Principles Board Opinion No. 20, "Accounting Changes". It is assumed that prior period adjustments for accounting purposes will be rare.

per agency request 10/18/2023 (TH)

ACCOUNTING FOR MANAGED CARE AND OTHER CONTRACTS

1062
(Rev. October 2023)

Long-term care facilities are contracting with HMO's, and other health care organizations. Instead of receiving payment on a fee for service basis, the facilities are generally being paid under one of ~~three~~ *two* methodologies to be discussed later in this chapter.

To provide a common understanding, the terms used in this chapter are defined below:

Capitation Fee - A fixed amount (usually per individual) that is paid periodically (usually monthly) to the contracting facility as compensation for providing comprehensive health care services for the period. The fee is set by contract between a prepaid health care plan (e.g., HMO) and provider.

Contracting Facility - The facility (e.g., a nursing home) which has contracted with a prepaid health care plan (e.g., HMO) to provide services for members on a risk-based capitation fee basis.

Copayment - A payment required to be made by a member to the contracting facility when specific health care services are rendered. Typical copayments included fixed charges for each prescription or certain elective procedures.

Health Maintenance Organization (HMO) - ~~A generic set of medical~~ *Health* care organizations organized to deliver and finance health care services. An HMO provides comprehensive health care services to enrolled members for a fixed fee.

Member - An individual who is enrolled as a subscriber, or an eligible dependent of a subscriber, in a prepaid health care plan *or insurer* (e.g., HMO *or PPO*).

The most common contracts fit into the following two categories:

1. Per Diem - This is a contract with an agency to accept a fixed amount per patient day. Generally, fixed rate per diem contracts are based on rates discounted from established rates, including managed care providers such as a health maintenance organization (HMO) and hospitals. Medi-Cal also pays long-term care facilities based on fixed rates. An example of the accounting entries for a fixed rate contract transaction follows. Assume that the facility has a contract to provide care at $100 per day to members of an HMO, and that the facility's normal charge is $125 per day:

June 1 To record a fixed rate contract and revenues from an individual patient:

Dr.	1039	Other Accounts Receivable	$125	
Cr.	3100.~~01~~*15*	Skilled Nursing Care - *Medi-Cal* Managed Care		$125

June 30 To record payment from HMO:

Dr.	1001	Cash	$100	
Cr.	1039	Other Accounts Receivable		$100

June 30 To record the discount from an individual patient:

Dr.	53~~10~~*20*.~~01~~*15*	Contractual Adjustments - ~~Managed Care~~*Medi-Cal*	$25	
Cr.	1039	Other Accounts Receivable		$25

2. Capitation Contract - Under this arrangement, the facility agrees to treat the members of the health plan for a fixed rate per member per month. The facility is at risk and is liable for any expenses incurred beyond the monthly capitation payments. Under certain circumstances, an HMO may remit payments in advance to facilities for services not yet identified. Situations such as this should be accounted for similarly to the accounting for capitated contracts. Facilities may purchase what is termed reinsurance which will indemnify the facility for any patient whose charges exceed a stop loss amount.

To record a capitation contract and revenues:

June 1 To record the capitation ($100 per member for 10 members):

Dr.	1001	Cash	$1,000	
Cr.	2049	Advances - Other Third-Party Payors		$1,000

June 10 To record revenues (one member receives services for two days at $125 a day):

Dr.	2049	Advances - Other Third-Party Payors	$250	
Cr.		Various Revenue Accounts		$250

June 30 To record remaining advances as revenue:

Dr.	2049	Advances - Other - Third-Party Payors		$750
Cr.	53*3*~~1~~0.~~01~~ *11*	Contractual Adjustments - ~~Managed Care~~*Commercial Coverage*		$750

OTHER DEDUCTIONS FROM REVENUE

1063
(Rev. October 2023)

per agency request 10/18/2023

In addition to not charging full standard rates for contractual reasons, a facility may choose to charge less than the standard rates for charitable or administrative reasons. In such cases, the facility again must record revenue at full established rates accompanied by a charity adjustment (Account 5100) or administrative adjustment (Account 5200). These adjustment accounts will be reported as deductions from revenue in a manner similar to that used for contractual adjustments. Individual cases should be examined at the time the revenue is recorded and the reason for any adjustment should be identified. The entry recording the adjustment can then be made at the same time as the revenue is recorded, or later at the end of the period. For example, suppose that, for charitable reasons, a decision is made to charge an individual only $80 of the normal $100 per month fee in an intermediate care facility. The proper treatment of this situation would be:

June 1	Dr.	1023	Accounts Receivable - Private	$80	
	Dr.	5100	Contractual Adjustments - Charity	20	
	Cr.	3200.00	Intermediate Care - Self-Pay		$100

per agency request

The amount of total charity care incurred in a reporting period, must be disclosed as a footnote to the facility's report.

TIMING DIFFERENCES

1150
(Rev. October 2023)

Timing differences result when accounting policies and practices used in an organization's accounting records differ from those used for reporting operations to governmental units collecting taxes or to outside agencies making payments based upon those reported operations.

These timing differences must be reflected on the long-term care facility's accounting records. The two types of timing differences are income tax allocation and third-party reimbursement.

Example of Timing Differences:

The following condensed income statement illustrates a timing difference attributable to different methods of calculating depreciation expense for books and for federal taxes and third-party reimbursement.

Assumptions:

1. Depreciation for accounting purposes is calculated on the straight-line method and amounts to $10 for the current year.

2. Depreciation for tax and third-party reimbursement purposes is calculated on a declining balance method and amounts to $20 for the current year.

3. The tax rate is forty percent.

4. The third-party utilization is fifty percent.

5. The only deduction from revenue is the contractual adjustment.

	Accounting Records	Tax/Cost Report
Revenue	$180	$180
Deductions from Revenue (B)	30	25
Net Revenue	150	155
Expenses (excluding Depreciation)	110	110
Depreciation	10	20
Total Expenses before taxes	120	130
Income before taxes	30	25
Taxes (A)	12	10
Net Income	$ 18	$ 15

(A) The income tax expense comprises three components: (1) $10 currently payable, (2) $4 payable in future periods related to the tax effect of the difference between depreciation expense for accounting and tax purposes (40% X $10 = $4), and (3) $2 to be applied against tax liabilities in future periods, related to the tax effect of the differences in reimbursement caused by the difference between depreciation for accounting purposes and cost report purposes, computed as follows:

40% (Tax effect) X 50% (Third-party utilization) X $10 (Difference between depreciation for accounting and cost report purposes) = $2

The journal entry to record these items is:

Dr.	1111	Prepaid Income Taxes	$ 2	
Dr.	9201.89	Provision for Income Taxes - Federal - Current	12	
Cr.	2071	Federal Income Taxes Payable		$10
Cr.	2112	Deferred Taxes Payable - Federal		4

(B) The deduction from revenue (contractual adjustment) is calculated as follows:

	Accounting Records	Tax/Cost Report
Medicare Revenue ($180 X 50%)	$ 90	$ 90
Reimbursable Costs:		
$120 X 50%	60	
$130 X 50%	—	65
Contractual Adjustment - *Medicare*	$ 30	$ 25

Of the $30 contractual adjustment for accounting purposes, $25 is the current portion and $5 is the deferred portion. The journal entry to record this expense is:

Dr.	5310	Contractual Adjustments - *Medicare*	$30	
Cr.	1042	Allowance for Contractual Adjustments - Medicare		$25
Cr.	2121	Deferred Revenue - Medicare Reimbursement		5

TH 10/18/2023 per agency request

DEPRECIATION

1160 (Rev. October 2023)

As mentioned earlier in this section, depreciation is the process by which the original cost of a physical asset is assigned to the periods in which it provides service. There are several techniques that are used to determine the amount of depreciation charged to each period of service. The simplest and most common of these is the straight-line method, which assigns to each period an equal portion of the asset's cost. NOTE: THE STRAIGHT-LINE METHOD MUST BE USED TO ACCOUNT FOR AND REPORT DEPRECIATION FOR ASSETS ACQUIRED ON OR AFTER AUGUST 1, 1970. In applying the straight-line method, the estimated salvage value of the asset, if any, is subtracted from its cost, and the resulting figure is divided by the estimated useful life of the asset. Estimates of useful lives used in computing depreciation should be taken from the recommendations made in the ~~1988~~ *2018* edition of Estimated Useful Lives of Depreciable Hospital Assets by the American Hospital Association. However, with the rapidly changing technology in health care facilities, these recommendations may not be comprehensive; in that case, the manufacturer should be consulted.

For example, the depreciation for a piece of equipment purchased for $1,500 and having an estimated salvage value of $200 at the end of 10 years of service would be $130 per year ($1,500 minus $200, divided by 10 years). The entry to record depreciation for this asset would be:

Dr.	7140.92	Depreciation and Amortization - Equipment	$130	
Cr.	1291	Accumulated Depreciation - Major Movable Equipment		$130

Notice that the credit is not to the Equipment asset account, but to an account called "Accumulated Depreciation - Major Movable Equipment". The use of this account allows the retention of the original cost of an asset in the accounting records. The remaining undepreciated cost, or book value, can be readily determined by subtracting the balance in the Accumulated Depreciation account from the asset account:

Equipment	$1,500
Accumulated Depreciation - Equipment	130
Book Value	$1,370

Other techniques of computing depreciation, such as the sum of the years digits method and the double declining balance method, are called accelerated methods, since they result in larger amounts of depreciation in the years when an asset is new and cause the book value to be reduced at a faster rate. Accelerated methods of depreciation may be used by long-term care facilities only for those assets which have been acquired before August 1, 1970. For assets acquired on this date or after, the straight-line method must be used to compute depreciation for reporting purposes. Facilities are permitted to continue to compute and report depreciation on an accelerated method for older assets which have been consistently depreciated on an accelerated method.

A special problem occurs in computing depreciation expense on an asset for the periods of acquisition and disposal. If a purchase or disposal is made during a period, depreciation should be reported only for the portion of the period for which the asset is held. For example, if the annual reporting period ended on December 31, and an asset was acquired three months earlier on September 30, then only 3/12 of a year's depreciation should be reported. However, to comply with this requirement literally could require extensive calculations involving only minor amounts. To avoid this additional work, a facility is permitted to adopt a policy similar to one of those presented below in lieu of exact calculation:

1. Record one-half of the yearly depreciation expense in the years of acquisition and disposal, regardless of the actual date of the action.

2. Record a full year's depreciation if the asset was acquired during the first half of the year or disposed of during the second half, and record no depreciation if it was acquired in the second half of the year or disposed of in the first half.

TH 10/18/2023 per agency request

The policy established, however, must be followed consistently from year to year and for all assets.

CONSOLIDATIONS

1320 (Rev. October 2023)

Foundations, auxiliaries, guilds, and similar organizations frequently assist and, in many instances, are related to health care entities. ~~While ARB No. 51 and FASB Statement No. 94~~ *Accounting Standards Codification (ASC) 810-10* provide*s* guidance on consolidations of related organizations, each separately licensed health facility must maintain separate balance sheet and income statement accounts and report separately to the Office.

per agency request

CHAPTER 2000 – Chart of Accounts

STATEMENT OF INCOME ACCOUNT NUMBERS

2012 (Rev. October 2023)

This section of the Chart of Accounts has been developed according to functional reporting concepts. That is to say, all revenues and expenses will be accounted for and reported according to type of activity.

First digit	-	As explained in Section 2010, the first digit of a revenue or expense account will be either "3", "4", "5", "6", "7", "8", or "9" which indicates the financial statement classification of that account.
Second and Third digits	-	The second and third digits represent classifications of revenues and expenses by type of service.
Fourth digit	-	As described for the balance sheet account numbers, the combinations of primary revenue and expense account numbers which end in zero (XXX0.XX) indicate required accounting and reporting level accounts. All other numbers in the fourth digit indicate subclassifications of the reporting levels which are optional.
Fifth and Sixth digit	-	Revenue accounts - The fifth and sixth digits are used to indicate subclassifications of patient service revenue and deductions from revenue. The fifth digit represents patient classification. The sixth digit represents category of payor. Expense accounts - The fifth and sixth digits are used to indicate the natural classification of expense. Since the four primary digits indicate the activity, these natural classifications are intended to specify the type of expense within each activity. A list of the classifications, including those that are required are listed in Sections 2230 and 2240.

The following is an example of revenue and expense account numbers for the charge and purchase of a prescription drug.

CHARGE

4300.00 - 4XXX.XX - Ancillary Services Revenue

X30X.XX - Pharmacy

XXX0.XX - Accounting and Reporting Level
XXXX.0X - Inpatient *Fee-for-Service*

XXXX.X0 - Classification of Payor - Self-Pay

If the purchaser of the prescription drug was an inpatient covered by Medi-Cal *Managed Care* then the charge would be as follows:

4300.05 - 4XXX.XX - Ancillary Services Revenue

X30XX.XX - Pharmacy

XXX0.XX - Accounting and Reporting Level

XXXX.~~0~~*1*X - Inpatient – *Managed Care*

XXXX.X5 - Classification of Payor - Medi-Cal

All other classifications of payor not listed at 2230 should be classified as .X9 - Other.

PURCHASE

8300.53 - 8XXX.XX - Ancillary Services Expense

X30X.XX - Pharmacy

XXX0.XX - Accounting and Reporting Level

XXXX.5X - Supplies

XXXX.X3 - Pharmaceuticals

See Section 2013.1, 2013.2 and 2230 for summary tables provided for easy account number reference.

Deductions from Revenue

2210.3
(Rev. October 2023;

per agency request 10/18/2023 TH

5100 _____ CHARITY ADJUSTMENTS

5200 _____ ADMINISTRATIVE ADJUSTMENTS

5310 _____ CONTRACTUAL ADJUSTMENTS - MEDICARE

5320 _____ CONTRACTUAL ADJUSTMENTS - MEDI-CAL

5330 _____ CONTRACTUAL ADJUSTMENTS - ~~MANAGED CARE~~
Commercial Coverage

5340 _____ CONTRACTUAL ADJUSTMENTS - OTHER PAYERS

5400 _____ OTHER DEDUCTIONS FROM REVENUE

10/18/2023 per agency request

SUBCLASSIFICATIONS OF PATIENT SERVICE REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE

2230
(Rev. October 2023)

Decimal Point	Fifth Digit	Patient Classification Description	Sixth Digit	Financial Status Classification Description	Seventh Digit	Special Program Classification*
.	0	INPATIENT – *FEE FOR SERVICE* (Required)	0	SELF-PAY - (Required)	0	(Optional)
.	1	*INPATIENT – MANAGED CARE (Required)* ~~(Optional)~~	1	*COMMERCIAL COVERAGE* ~~MANAGED CARE~~ - (Required)	1	Sub-Acute Care
.	2	(Optional)	2	~~COMMERCIAL INSURANCE/ BLUE CROSS - (Optional)~~	2	Sub-Acute Care - Pediatric
.	3	(Optional)	3	VETERANS ADMINISTRATION - (Optional)	3	Transitional Inpatient Care
.	4	OUTPATIENT – *FEE FOR SERVICE* (Required)	4	MEDICARE - (Required)	4	(Optional)
.	5	*OUTPATIENT – MANAGED CARE (Required)* ~~(Optional)~~	5	MEDI-CAL - (Required)	5	(Optional)
.	6	(Optional)	6	SHORT DOYLE - (Optional)	6	(Optional)
.	7	(Optional)	7	OTHER GOVERNMENT - (Optional)	7	(Optional)
.	8	(Optional)	8	CHARITY - (Required)	8	(Optional)
.	9	NON-PATIENT	9	OTHER PAYERS - (Required)	9	(Optional)

* The seventh-digit subclassifications for Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care must be used by those facilities contracting with the Department of Health *Care* Services to provide these types of care.

per agency request 10/18/2023 TH

5100 CHARITY ADJUSTMENTS

See Chapter 1000 for definition.

5200 ADMINISTRATIVE ADJUSTMENTS

The account for administrative adjustments must be used for the difference between a patient's charges, recorded at the facility's full established rates, and the amount the facility actually expects to collect from the patient, when that difference is not due to a contractual obligation with third party payors, a continuing care contract, or charity allowances. Such administrative adjustments might result from:

- A rate reduction to meet competitive conditions.
- Provision of services at preferential rates to specific individuals, e.g., employee dependents.

An effort should be made by all facilities to distinguish such allowances from those granted for reasons of charity.

5310 CONTRACTUAL ADJUSTMENTS - MEDICARE

5320 CONTRACTUAL ADJUSTMENTS - MEDI-CAL

5330 CONTRACTUAL ADJUSTMENTS - ~~MANAGED CARE~~ *COMMERCIAL COVERAGE*

5340 CONTRACTUAL ADJUSTMENTS - OTHER PAYERS

Accounts 5310, 5320, 5330 and 5340 must be charged with the difference between the amount of the charges (based on the full established rates) for services which are rendered during the reporting period and are covered by a third-party contract, and the amount received or to be received from third-party agencies in payment of such charges. For facilities with continuing care contracts, account 5340 also includes the difference between the amount of charges (based on full established rates) and the amount of deferred advance fees amortized during the period, and any other amounts received or to be received as payment. If any part of these differences is recoverable from a patient, it should be treated as a private inpatient or outpatient receivable and, if uncollectible, should be charged against the allowance for uncollectible accounts-not these contractual adjustment accounts.

5400 OTHER DEDUCTIONS FROM REVENUE

Other deductions from revenue which are not included elsewhere should be credited to this account.

SUBCLASSIFICATIONS OF PATIENT SERVICE REVENUE ACCOUNTS AND DEDUCTIONS FROM REVENUE

3230
(Rev. October 2023)

per agency request 10/18/202 TH

The following provide definitions to the classifications shown in the chart in Section 2230.

***Patient* Financial Status Classification**

Fifth Digit

.0X Inpatient Fee-for-Service – a patient who receives inpatient services and is enrolled in a coverage program that pays on a fee-for-service basis. Under fee-for-service programs, providers are reimbursed based on individual services provided.

.1X Inpatient Managed Care – a patient who receives inpatient services and is enrolled in a managed care plan. Under managed care, providers contract with health plans to deliver benefits in exchange for a monthly fee.

.4X Outpatient Fee-for-Service – a patient who receives outpatient services and is enrolled in a coverage program that pays on a fee-for-service basis. Under fee-for-service programs, providers are reimbursed based on individual services provided.

.5X Outpatient Managed Care – a patient who receives outpatient services and is enrolled in a managed care plan. Under managed care, providers contract with health plans to deliver benefits in exchange for a monthly fee.

Sixth Digit

.X0 Self-Pay - ~~a patient who~~ *includes patients who are financially responsible for their own care and who are not covered by a third-party payer.* ~~is not covered by any type of coverage~~.

.X1 ~~Managed Care – These are patients who belong to groups (HMO's, PPO's or others) that have a contractual relationship with the facility. Managed Care includes patients enrolled in managed care plans funded by Medicare, Medi-Cal or other government programs, as well as patients enrolled in commercial managed care programs.~~ *Commercial Coverage – These patients have private coverage that is employer/employment-sponsored or privately purchased. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.*

.X2- ~~Commercial Insurance/Blue Cross – These are patients who have their own insurance company which typically pays on a percentage of charges basis.~~

.X3 Veteran's Administration

.X4 Medicare - patients covered under the *Medicare program*. ~~Social Security Amendments of 1965.~~ These patients are primarily *seniors and people with disabilities.* ~~the aged and needy.~~

.X5 Medi-Cal - a patient in this classification is one who ~~qualified as needy under state laws~~ *is enrolled in Medi-Cal – California's Medicaid program for low-income people*.

.X6 Short-Doyle - A state created program to offset the cost to the county for treating mentally ill patients who otherwise could not afford treatment and are not insured.

.X7 Other Governmental - patients covered by governmental programs not identified above.

.X8 Charity - See Section 1063.

.X9 Other Payers - all other financial classes not covered above, including patients covered by continuing care contracts. (Revenue for patients with a continuing care contract, but where the primary payer is one of the above payer classifications, should be recorded and reported by the primary payer.)

Special Program Classification

Seventh Digit

.XX0 Other (Undesignated)

.XX1 Sub-Acute Care

.XX2 Sub-Acute Care - Pediatric

.XX3 Transitional Inpatient Care

.XX4-

.XX9 Other (Undesignated)

The seventh digit subclassifications above must be used by all facilities contracting with the Department of Health *Care* Services to provide Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care to provide these types of care to Medi-Cal patients. These subclassifications must be used to record gross charges for all routine and ancillary services delivered to patients in the units identified in the contracts with the Department.

CHAPTER 4000 – Reporting Requirements and Instructions

Page 10.4 – Adjustments to Trial Balance Expenses and Related Party Transactions

4020.3.2
(Rev. October 2023)

per agency request 10/18/2023 TH

This page is a supplemental worksheet for Page 10.1.

This page must be completed for all facilities that had costs or revenue included in the Statement of Income for the current reporting period which are a result of transactions with related persons or organizations as defined in Section 4020.3.1 of the Manual.

Medi-Cal providers are advised that where allowable Medi-Cal costs are not otherwise defined by the State; the facility must refer to the Provider Reimbursement Manual; Parts 1 and 2 (Publications 15-1 and 15-2) issued by the U.S. Centers for Medicare and Medicaid Services for the determination of reasonable, allowable costs.

- Enter in Column 1 the name of the Related Party with which the facility transacted.
- Enter in Column 2 the number of individuals that provided the goods and/or services at the facility.
- Enter in Column 3 the description of the goods and/or services related to the transaction disclosed in Column 1 (this may be the name of the cost center where the expenses are reported on Page 10.1 (e.g. Laundry & Linen)).
- If the related party provides goods and/or services to non-related parties, enter "Yes" in Column 4 and complete Column 5 with the percentage of goods and/or services that are provided to non-related parties. If the related party does not provide goods and/or services to non-related parties, enter "No" in Column 4 and do not complete Column 5.
- Enter in Column 6 the Line number on the Trial Balance (Page 10.1) where the expense to be adjusted is reported.
- Enter in Column 7 the Transaction Amount which is included in the amount reported on Page 10.1, Column 4 if the transaction resulted in an expense. If the transaction resulted in revenue earned by the facility, be sure to enter the amount as a <credit>.
- Enter in Column 8 the Healthcare Portion of the transaction. This amount is included in the amount reported on Page 10.1, Column 10. For facilities that have both residential and healthcare services, the healthcare portion of the transaction should be calculated utilizing the same ratio to the transaction amount as the related healthcare expense was to total expense on Page 10.1, Column 8.

Column 9-11 must be completed for **Medi-Cal Providers, Only.**

For additional guidance on adjustments, refer to Manual Section 4020.3.

- Enter in Column 9 the total amount of the required adjustment and whether it is an increase or <decrease> adjustment.
- Enter in Column 10 the amount of the total adjustment in Column 9 which relates to the healthcare portion. For facilities that have both residential and healthcare

services, the healthcare portion of the adjustment should be calculated utilizing the same ratio to the total adjustment amount as the related healthcare expense was to total expense on Page 10.1, Column 8 (i.e. if healthcare expenses are 80% of a given cost center, then healthcare should receive 80% of the related adjustment amount entered in Column 9. For non-residential care providers, Column 10 will be the same as Column 9.

- Enter in Column 11 the total amount of the transaction that is being claimed for Medi-Cal reimbursement.

Page 10.1 - Expense Trial Balance Worksheet

4020.4
(Rev. October 2023)

per agency request 10/18/2023 TH

This report page provides for the reporting of the trial balance of expenses from the facility's accounting books and records. It also provides for the direct assignment and apportionment of expenses related to both residential care and health care activities.

Finally, it provides for offsetting other operating revenue in column 11, and for Medi-Cal program adjustments in column 13.

Each account title is labeled with an account number from the Office of Statewide Health Planning and Development (OSHPD) Uniform Accounting System. This is the required system of accounting and reporting for all long-term care facilities in California.

COLUMNS 1, 2, 3, and 4

- List on the appropriate lines in columns 1, 2, 3, and 4 the total expenses incurred during the reporting period. The expenses must be detailed between salaries and wages (column 1), employee benefits (column 2), and other expenses (column 3). Column 1 includes only salaries and wages related to productive hours. Compensation for time off, along with all other employee benefits, must be included in column 2. The sum of columns 1, 2, and 3 must equal column 4. Do not change or add line labels. Also, do not draw additional lines in any column.

- For columns 1, 2, and 3, enter the sum of lines 5 through 170 on line 175.

- Complete the Supplemental Expense Information items on lines 180, 185, and 190 as indicated below.

  - Enter raw food costs, natural expense classification .55, on line 180, column 3.

  - Enter total Workers' Compensation Insurance expense, natural expense classification .27, on line 185, column 2.

  - Enter total State Unemployment Insurance expense, natural expense classification .22, on line 190, column 2.

- For column 4, enter the sum of lines 5 through 135 on line 150, and enter the sum of lines 150 through 170 on line 175.

  Note: Periodic hair trims must be provided to Medi-Cal patients without charge. The expenses related to providing the periodic hair trims to Medi-Cal patients must be accounted and reported as an expense of the appropriate routine services cost centers. All other beauty and barber expenses are to be reported as "Other Ancillary Services" on line 100. For Medi-Cal providers only, beauty and barber expenses included in Other Ancillary Services are then adjusted in column 13 by transferring the expenses from line 100 to line 140.

COLUMNS 5 through 9

- Columns 5 through 9 must be completed only by those facilities providing residential care activities as well as health care activities. All others transfer the amounts in column 4 to column 10.

COLUMN 5 - Residential Care Facilities Only

- Enter in column 5 for each line item those expenses included in column 4 which are directly identifiable as residential care expenses. (Directly identifiable expenses are defined as those expenses which require no computations to determine, e.g., invoiced amounts related to residential care only). Total lines 5 through 70 and enter the result on line 150. Total lines 150 through 170 and enter the result on line 175.

COLUMN 6 - Residential Care Facilities Only

- Enter in column 6 for each line item those expenses included in column 4 which are directly identifiable as health care expenses. (Directly identifiable expenses are defined as those expenses which require no computation to determine, e.g., invoiced amounts related to health care only.) Total lines 5 through 170 on line 175.

COLUMN 7 - Residential Care Facilities Only

- Subtract columns 5 and 6 from column 4 for lines 5 through 70, and for lines 155 through 175, and enter the results in column 7.

COLUMNS 8 and 9 - Residential Care Facilities Only

For allocations in column 8, the following definitions apply:

Square feet -

The number of square feet in each health care section and the nonhealth care section of the facility should be determined either by a physical measurement of the facility or by a measurement from blueprints. Floor area measurements should be taken from the center of walls to the center of adjoining corridors if a hallway services more than one department. Hallways, waiting rooms, storage areas, etc., serving only one section should be included in that section. Exclude stairwells, elevators, and other shafts. General and unused areas are also to be excluded. When changes in assigned area have been made during the year as a result of new construction, relocation, expansion, or curtailment of services, statistical data should be maintained to allow for the development of "weighted" areas for the fractional part of the year. For example, the addition or deletion of 1,200 square feet for a six-month period would be an adjustment of 600 square feet. Where the same area serves more than one function, this area must be apportioned between or among the appropriate functions.

Clean dry pounds of linen processed -

If a summary of actual pounds processed during the current period, segregated by residential care activities and health care activities, is not available, a study should be made to determine the percentage of laundry processed for each. Those percentages should then be multiplied by total clean, dry pounds processed during the current period to arrive at the necessary statistics.

Meals served -

The number of meals served to residents and the number of meals served to patients, excluding snacks and fruit juices served between the three regularly scheduled meals.

- Enter the apportionment factor (fraction expressed as a decimal carried to 6 decimals) of total statistics, which are used in providing residential care, by cost center on lines 5 through 70 according to the following:

- Lines 5 through 55 (apportionment factor for residential care portion of total square feet) are calculated as follows:

Total square feet used in providing residential care	÷	Total square feet of facility used in providing residential care and health care	=	Apportionment factor for total square feet allocable to residential care

- Line 60 (apportionment factor for residential care portion of total clean, dry pounds of linen processed) is calculated as follows:

Total pounds of clean dry linen processed for residential care	÷	Total pounds of clean dry linen processed for residential and health care	=	Apportionment factor for total pounds of linen processed allocable to residential care

- Line 65 (apportionment factor for residential care portion of total meals served) is calculated as follows:

Number of residential care meals served	÷	Total residential and health care meals served	=	Apportionment factor for total meals served allocable to residential care

- Line 70 (apportionment factor for residential care portion of total revenue) is calculated as follows:

Total residential care revenue recorded in Account 9100	÷	Total revenue (Accounts 3100 through 4900 + residential care revenue)	=	Apportionment factor for total revenue allocable to residential care

- At this point, the apportionment factors for all cost centers except Social Services, Activities, Administration, and Inservice Education - Nursing (lines 155 through 170) should be entered in column 8. Multiply column 7 times column 8, for line 5 through 70, and enter the results in column 9.

- Total lines 5 through 70, column 9 and enter the result on line 150.

- To calculate the apportionment factor for Social Services, Activities, Administration, and Inservice Education - Nursing, column 9, lines 155 through 170, perform the following calculation:

Line 150, columns 5 and 9 ÷ Line 150, column 4	=	Apportionment factor of accumulated cost allocable to residential care

- Enter the results to six decimal places in column 8, lines 155 through 170.

- Multiply column 7, lines 155 through 170 times column 8, lines 155 through 170 and enter the results in column 9, lines 155 through 170.

  Note: No other apportionment bases are to be used without the prior written approval of the Office.

- Total lines 150 through 170, column 9 and enter the result on line 175.

COLUMN 10

- Subtract columns 5 and 9 from column 4 and enter the results in column 10, lines 5 through 170.

- Total lines 5 through 170, column 10 and enter the results on line 175.

  Note: The expenses relating to health care in column 10 must be transferred to the Statement of Income - General Fund, page 8. The total of the residential care expenses (column 5, line 175) must be netted against residential care revenues and included in nonhealth care revenues and expenses, column 1, line 210 of the Statement of Income (page 8).

COLUMNS 11 and 12

- The amounts in column 11 are brought forward from page 10.2 to the appropriate lines on this page. Then, for all lines, subtract column 11 from column 10, and enter the results in column 12.

COLUMNS 13 and 14 - (Medi-Cal Providers Only)

These columns are to be completed by Medi-Cal providers only.

- The amounts in column 13 are brought forward from page*s* 10.3 *and 10.4* to the appropriate lines on this page. Use brackets to show adjustments decreasing expenses. Then, for all lines, add columns 10 and 13, and enter the results in column 14.

  Note: Beauty and Barber and Other Nonreimbursable Expenses must be entered on lines 140 and 145 respectively. Beauty and Barber expenses are reclassified from Other Ancillary Services in column 13.

- Total lines 5 through 170 and enter the result on line 175.

Page 4.1 - Facility Patient Days by Payer

4020.5
(Rev. October 2023)
per agency request 10/18/2023 TH

Enter in columns 1 through ~~5~~ 8, the number of patient (census) days (including days for bedholds and leaves of absence) by payer and by routine services revenue center.

Count the day of admission, but not the day of discharge. Count as one, each patient admitted and discharged the same day. If a patient moves from one routine services cost center to another, actual patient (census) days for each routine service must be reported. If a patient changes one payer category to another during his or her stay, report patient (census days) by the primary payer for each day.

Where appropriate, payer categories should be further broken down to differentiate Fee-for-Service from Managed Care programs as defined below:

Fee-for-Service *– Under a fee-for-service coverage program, beneficiaries can see any provider who accepts coverage, and providers are reimbursed for each individual service or visit.*

Managed Care *- Under a managed care plan, providers contract with health plans and insurers to deliver benefits in exchange for a monthly fee.*

- Complete column 1 with all patient days for which Medicare *Fee-for-Service* was the primary payer.
- Complete column 2 with all patient days for which ~~Medi-Cal~~ *Medicare Managed Care* was the primary payer.
- Complete column 3 with all ~~Self-Pay patient days (all patient days for which the primary payer is the patient or patient's family, not a third-party payer)~~ *patient days for which Medi-Cal Fee-for-Service was the primary payer.*
- Complete column 4 with all ~~Managed Care patient days (all patient days for which the primary payer is a health maintenance organization or other managed care plan)~~ *patient days for which Medi-Cal Managed Care was the primary payer.*
- Complete column 5 with *Commercial Coverage Fee-for-Service patient days.* (all patient days for which *private coverage that is employer/employment-sponsored or privately purchased is the primary payer. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.* ~~some other third-party is the primary payer (including Veterans Administration, Department of Mental Health, private long-term care insurance, continuing care contract, and charity patient days.~~).
- Complete column ~~5~~ 6 with *Commercial Coverage Managed Care patient days.* (all patient days for which *private coverage that is employer/employment-sponsored or privately purchased is the primary payer. This includes Covered California plans. It does not include coverage funded by Medicare, Medi-Cal, a county, Workers' Compensation, or other government programs.* ~~some other third-party is the primary~~

~~payer (including Veterans Administration, Department of Mental Health, private long-term care insurance, continuing care contract, and charity patient days.~~).

- *Complete column 7 with all Self-Pay patient days. (all patient days for which the primary payer is the patient or patient's family, not a third-party payer. Including Charity Care).*
- *Complete column 8 with Other Payer patient days. (all patient days that do not fall into any of the defined categories including Veterans Administration and Worker's Compensation).*
- Complete column ~~6~~ *9*, lines 5 through 70, with the totals of columns 1 through ~~5~~ *8* for each line.

Page 4.2 - Facility Revenue Information

4020.6
(Rev. October 2023)

per agency request 10/18/2023 TH

Gross revenue must be accounted and reported at the facility's full-established rates for the routine and ancillary services provided during the period, regardless of the amounts received or to be received as reimbursement for the services. Do not adjust gross revenues for contractual adjustments, cost report settlements, administrative and charity adjustments, or other deductions from revenue for reporting revenues in columns 2, 4, 6, 8, *10, 12, 14 and 16.*

Gross routine services and ancillary services revenue must be accounted and reported by payer category, based on the primary payer for the patient receiving the services. For example, if a patient's routine services are reimbursable by Medi-Cal, but their ancillary services are reimbursable by Medicare Part B, both the routine and ancillary services should be recorded as Medi-Cal revenue.

For each routine and ancillary service:

- Complete column 1 with gross inpatient Medicare *Fee-for-Service* revenue.
- Complete column 2 with gross outpatient Medicare *Fee-for-Service* revenue.
- Complete column 3 with gross inpatient ~~Medi-Cal~~ *Medicare Managed Care* revenue.
- Complete column 4 with gross outpatient ~~Medi-Cal~~ *Medicare Managed Care* revenue.
- Complete column 5 with gross inpatient ~~Self-Pay~~ *Medi-Cal Fee-for-Service* revenue.
- Complete column 6 with gross outpatient ~~Self-Pay~~ *Medi-Cal Fee-for-Service* revenue.
- Complete column 7 with gross inpatient *Medi-Cal* Managed Care revenue.

- Complete column 8 with gross outpatient *Medi-Cal* Managed Care revenue.
- Complete column 9 with gross inpatient ~~Other Payer~~ *Commercial Coverage Fee-for-Service* revenue.
- Complete column 10 with gross outpatient ~~Other Payer~~ *Commercial Coverage Fee-for-Service* revenue.
- *Complete column 11 with gross inpatient Commercial Coverage Managed Care revenue.*
- *Complete column 12 with gross outpatient Commercial Coverage Managed Care revenue.*
- *Complete column 13 with gross inpatient Self Pay revenue.*
- *Complete column 14 with gross outpatient Self Pay revenue.*
- *Complete column 15 with gross inpatient Other Payer revenue.*
- *Complete column 16 with gross outpatient Other Payer revenue.*
- Complete column ~~11~~ *17*, lines 5 through 45 and lines 105 through 155, with the totals of columns 1, 3, 5, 7, *9, 11, 13* and ~~9~~*15* for each line.
- Complete column ~~12~~ *18* lines 105 through 155, with the totals of columns 2, 4, 6, 8, *10, 12, 14* and ~~10~~*16* for each line.
- Complete line 70, columns 1, 3, 5, 7, 9, 11, *13, 15 and 17* with the sums of lines 5 through 45.
- Complete line 170, columns 1 through ~~12~~ *18*, with the sums of lines 105 through 155.
- Complete line 175, columns 1 through ~~12~~ *18*, with the sums of lines 70 and 170.
- Enter Charity Adjustments on line 205, column*s* 1*3 and 14*.
- Enter Administrative Adjustments on line 210, column*s* 1*3 and 14*.
- Enter Contractual Adjustments – Medicare on line 215, column*s* 1 *through 4*. Include all Medicare settlements related to Medicare cost reports for prior periods that were not determinable until the current period. If the Medicare cost report for the current period has not yet been completed, be sure that contractual adjustments for the current period reflect the facility's best estimate of final reimbursement for services provided to Medicare recipients during the period.

- Enter Contractual Adjustments - Medi-Cal on line 220, column*s ~~1~~ 5 through 8*.
- Enter Contractual Adjustments - ~~Managed Care~~*Commercial Coverage* on line 222, column*s ~~1~~ 9 through 12*.
- Enter Contractual Adjustments - Other Payer on line 225, column*s ~~1~~ 15 and 16*.
- Enter all Other Deductions from Revenue on line 230, column*s* 1 *through 16*.
- *For all columns, complete line 240 with the sum of lines 205 through 230.*
- *For all columns, complete line 250 with the sum of line 175 minus line 240.*
- *Complete Column 17, line 205 with the sum of odd columns (1, 3, 5, 7, 9, 11, 13, 15).*
- *Complete Column 18, line 205 with the sum of even columns (2, 4, 6, 8, 10, 12, 14, 16).*
- *Complete Column 17, line 210 with the sum of odd columns (1, 3, 5, 7, 9, 11, 13, 15).*
- *Complete Column 18, Line 210 with the sum of even columns (2, 4, 6, 8, 10, 12, 14, 16).*
- *Complete Column 17, line 215 with the sum of columns 1 and 3.*
- *Complete Column 18, Line 215 with the sum of columns 2 and 4.*
- *Complete Column 17, line 220 with the sum of columns 5 and 7.*
- *Complete Column 18, Line 220 with the sum of columns 6 and 8.*
- *Complete Column 17, line 222 with the sum of columns 9 and 11.*
- *Complete Column 18, Line 222 with the sum of columns 10 and 12.*
- *Complete Column 17, line 225 with the amount in column 15.*
- *Complete Column 18, Line 225 with the amount in column 16.*
- *Complete Column 17, Line 230 with the sum of odd columns (1, 3, 5, 7, 9, 11, 13, 15).*
- *Complete Column 18, Line 230 with the sum of even columns (2, 4, 6, 8, 10, 12, 14, 16).*
- *Complete Column 19, all lines, with the sum of columns 17 and 18.*

Page 4.3 - Other Census and Revenue Information

4020.7
(Rev. October 2023)
per agency request 10/18/2023 TA

- Enter the number of licensed beds at the end of the current reporting year in column 1, line 5. This figure is based on the number of beds according to the facility's license (excluding beds in suspense) at the end of the reporting period.

- In column 1, line 10, enter the average number of licensed beds at the end of each month of the current reporting period. This figure is based on the number of beds according to the facility's license (excluding beds in suspense) and must reflect any change made in the number of licensed beds during the reporting period.

- Enter the number of available beds (those set up and staffed for use, both filled and empty) at the end of the current reporting period in column 1, line 20. These beds are counted according to number in use, not licensed.

- Enter the average number of available beds (those set up and staffed for use, both filled and empty) at the end of each month during the current reporting year in column 1, line 25. These beds are counted according to number in use, not licensed.

- Enter the total number of admissions during the current reporting period in column 1, line 40. Do not include those patients who transferred from one type of care to another within the same facility, or returned to the facility under a bedhold or administrative leave. Include those patients admitted to the Skilled Nursing or Intermediate level of care from the Residential level of care.

- Enter the total number of discharges during the current reporting period in column 1, line 45. Do not *include* those patients who transferred from one level of care to another within the same facility or left the facility under a bedhold or administrative leave. Include those patients who transferred from the Skilled Nursing or Intermediate level of care to the Residential level of care within the same facility.

- Enter the Occupancy Rate on line 60, column 1. Occupancy rate is calculated by dividing the number of Total Patient (Census) Days in column ~~6~~ 9, line 70, page 4.1 by Average Licensed Beds (line 10) multiplied by the number of days in the reporting period (usually 365); then multiplying that result by 100 to obtain a percentage. Round to two decimal places.

Special Care Program Contract Providers, Only

Complete lines 100 through 175 with the following detail of the patient (census) days recorded in the special care program units: Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care. For accounting and reporting purposes, Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care are defined as the care provided to patients in the units identified in the contracts with the Department of Health Services to provide these types of care to Medi-Cal beneficiaries.

Complete column 1 with the totals of the following patient (census) days in each special care program unit. Complete column 2 with the patient (census) days for the Medi-Cal beneficiaries in each special care program unit.

- Enter the number of patient (census) days for Ventilator-Dependent Sub-Acute Care patients on line 100.

- Enter the number of patient (census) days for other Sub-Acute Care patients on line 115.

- Total lines 100 and 115 on line 120. Line 120, column 1, must agree with total Sub-Acute Care patient (census) days on page 4.1, line 25, column ~~6~~ *9*. Line 120, column 2, must agree with Sub-Acute Care - Medi-Cal patient (census days) on page 4.1, line 25, column ~~2~~ *3 plus column 4*.
- Enter the number of patient (census) days for Ventilator-Dependent, Pediatric Sub-Acute Care patients on line 130.

- Enter the number of patient (census) days for other Pediatric Sub-Acute Care patients on line 145.

- Total lines 130 and 145 on line 150. Line 150, column 1, must agree with total Pediatric Sub-Acute Care patient (census) days on page 4.1, line 30, column ~~6~~ *9*.Line 150, column 2, must agree with Pediatric Sub-Acute Care - Medi-Cal patient (census) days on page 4.1, line 30, column ~~2~~ *3 plus 4*.

- Enter the number of patient (census) days for Transitional Inpatient Care – Medical Services patients on line 165.

- Enter the number of patient (census) days for Transitional Inpatient Care - Rehabilitation Services patients on line 170.

  Total lines 165 and 170 on line 175. Line 175, column 1, must agree with total Transitional Inpatient Care patient (census) days on page 4.1, line 35, column ~~6~~ *9*. Line 175, column 2, must agree with Transitional Inpatient Care - Medi-Cal patient (census) days on page 4.1, line 35, column ~~2~~ *3 plus 4*.

Medi-Cal Providers Only

- Enter on line 200, column 1, total charges billed to the Medi-Cal Intermediary (net of contractual adjustments).

- Enter on line 205, column 1, total patient liability (share of cost) amounts for patient charges billed to the Medi-Cal Intermediary.

- Enter on line 210, column 1, third party or other liability amounts for patient charges billed to the Medi-Cal Intermediary.

- Enter on line 215, column 1, noncovered charges included in patient charges billed to the Medi-Cal Intermediary.

- Enter on line 240, column 1, any other amounts adjusted from patient billings by the Medi-Cal Intermediary.

- Subtract lines 205 through 240, column 1 from line 200, column 1 and enter the result on line 250, column 1.

Page 11 - Allocation of Indirect Costs to Direct Costs Centers - Health Care Only

4020.8
(Rev. October 2023)

per agency request 10/18/2023 (TK)

The purpose of this worksheet is to allocate indirect costs to the Ancillary, Routine, and Non-reimbursable cost centers.

Medi-Cal Providers

- Enter on line 5, column 1, the sum of lines 5 through 65 and 155 through 170, page 10.1, column 14.

- Enter on line 5, column 3, the sum of lines 5 through 55 on page 10.1, column 14.

- Enter on line 5, column 5, the amount on page 10.1, column 14, line 60.

- Enter on line 5, column 7, the amount on page 10.1, column 14, line 65.

- Enter on line 5, column 9, the sum of lines 155, 160, and 170 on page 10.1, column 14.

- Enter on line 5, column 11, the amount on page 10.1, column 14, line 165.

- Enter in column 1, lines 10 through 80, the amounts from page 10.1, column 14, lines 75 through 145, respectively.

- Enter in column 2 the square footage statistic for each physically identifiable cost center. See Section 4020.4 (Cont. 2) for the definition of square feet. Percentages are not acceptable.

- Enter in column 4 the clean, dry pounds of laundry statistics for each cost center utilizing laundry and linen service. Include in the appropriate routine cost centers the pounds of patients' personal laundry for laundry services provided to patients without charge. Percentages are not acceptable. See note later in this section.

- Enter in column 6 the number of patient meals for each level of care. See Section 4020.2 for the definition of meals served. Percentages are not acceptable. See note later in this section.

- Enter in column 8, line 30, the amount from page 10.1, column 14, line 95. Enter in column 8, lines 40 through 70, the amounts from page 10.1, column 14, lines 105 through 135, respectively.

- Total columns 2, 4, 6, and 8 and enter the sum of each column on line 85.

- Determine the unit cost multiplier in column 2 by dividing the amount on line 5, column 3, by the total units on line 85, column 2. Calculate to 6 decimal places. Enter the result on line 90, column 2.

- Multiply the unit multiplier on line 90, column 2 by each of the amounts in column 2, lines 10 through 80, and enter the results on the corresponding lines in column 3.

- The above calculation exemplifies the process to be completed for columns 4 and 5, 6 and 7, and 8 and 9.

- Complete column 10 by adding columns 1, 3, 5, 7, and 9 for each line.

- Total column 10, lines 10 through 80, and enter the result on line 85.

- Calculate the unit multiplier on line 90, as instructed above.

- Add columns 10 and 11, all lines, and enter the results in column 12.

- Total columns 1, 3, 5, 7, 9, 10, 11, and 12, lines 10 through 80, and enter the result of each column on line 95.

- Transfer the amounts on lines 40 through 70, column 12, to line 100, columns 1 through 9.

- Enter on line 105 total patient (census) days of service by level of care in columns 1 through 9, from page 4.1, column ~~6~~ 9, lines 5 through 45.

- Compute the average cost per day in columns 1 through 9, by dividing line 100 by line 105 and enter the results on line 110 to two decimal places.

Note: While actual counts are preferred, it is acceptable to use data sampling to estimate the dietary and laundry and linen statistics for apportioning health care and non-health care expenses on page 10.1, and for allocating indirect costs to direct cost centers on page 11. While a statistical sampling method would produce the most accurate approximation of the actual counts, a reasonable sample is acceptable.

Dietary meals served can be estimated by first determining the average number of meals served per day (excluding snacks and refreshments served at other than meal time) and then multiplying the total number of patient days in each cost center during the reporting period by that average. In most cases the average will be 3 meals per day.

Pounds of laundry and linen can be estimated by weighing the clean laundry and linen used in each cost center for two-week periods at least four times a year. The accumulated results of these four two-week samples are then annualized by multiplying by 6.5. This should ensure a reasonable approximation of actual usage.

Non-Medi-Cal Providers

- Enter in column 2 the square footage statistics for each physically identifiable cost center. See Section 4020.2 for the definition of square feet. Percentages are not acceptable.

- Enter in column 4 the clean, dry pounds of laundry statistics for each cost center utilizing laundry and linen service. Percentages are not acceptable.

- Enter in column 6 the number of patient meals for each level of care. See Section 4020.2 for the definition of meals served. Percentages are not acceptable.

For Non-Medi-Cal providers, the remainder of this page will be completed by the Office.

Page 13 - Computation of Ancillary Services Cost per Patient Day - (Special Care Program Contract Providers, Only)

4020.9
(Rev. October 2023)

per agency request 10/18/2023 TH

The purpose of this worksheet is to allocate ancillary costs to Sub-Acute Care, Sub-Acute Care - Pediatric, and Transitional Inpatient Care, for Medi-Cal rate-setting purposes. Only providers who have contracted with the Department of Health Services to provide these types of care to Medi-Cal beneficiaries are required to complete this page.

- Enter on line 105, column 6, the total patient days for Sub-Acute Care from page 4.1, column ~~6~~ *9*, line 25. Enter on line 105, column 9, the total patient days for Sub-Acute Care - Pediatric from page 4.1, column ~~6~~ *9*, line 30. Enter on line 105, column 12, the total patient days for Transitional Inpatient Care from page 4.1, column ~~4~~ *9*, line 35.

- Enter in column 1, lines 10 through 35, the total expenses (allowable direct and indirect costs) for ancillary services from page 11, column 12, lines 10 through 35.Complete column 1, line 95, with the sum of lines 10 through 35.

- Enter in column 2, lines 10 through 35, the gross revenues for ancillary services from page 4.2, column ~~11~~ *17* plus ~~12~~ *18*, lines 105 through 155. Complete column 2, line 95, with the sum of lines 10 through 35.

- Divide column 1 by column 2 for lines 10 through 35 and enter the result for each line in column 3 to six decimal places.

- Enter in column 4, lines 10 through 35, the gross ancillary revenues related to Sub-Acute Care patients, from the facility trial balance (OSHPD Revenue subclassification 4XXX.XX1). Complete column 4, line 95, with the sum of lines 10 through 35.

- Multiply column 4 by column 3 for lines 10 through 35 and enter the result for each line in column 5 to the nearest dollar. Complete column 5, line 95, with the sum of lines 10 through 35.

- Divide each of the amounts in column 5, lines 10 through 95, by column 6, line 105, and enter the result for each line in column 6 to two decimal places.

- Enter in column 7, lines 10 through 35, the gross ancillary revenues related to Sub-Acute Care - Pediatric patients (OSHPD Revenue subclassification 4XXX.XX2), from the facility trial balance. Complete column 7, line 95, with the sum of lines 10 through 35.

- Multiply column 7 by column 3 for lines 10 through 35 and enter the result for each line in column 8 to the nearest dollar. Complete column 8, line 95, with the sum of lines 10 through 35.

- Divide each of the amounts in column 8, lines 10 through 95, by column 9, line 105, and enter the result for each line in column 9 to two decimal places.

- Enter in column 10, lines 10 through 35, the gross ancillary revenues related to Transitional Inpatient Care patients (OSHPD Revenue subclassification 4XXX.XX3), from the facility trial balance. Complete column 10, line 95 with the sum of lines 10 through 35.

- Multiply column 10 by column 3 for lines 10 through 35 and enter the result for each line in column 11 to the nearest dollar. Complete column 11, line 95, with the sum of lines 10 through 35.

- Divide each of the amounts in column 11, lines 10 through 95, by column 12, line 105, and enter the result for each line in column 12 to two decimal places.

Page 8 - Statement of Income - General Fund **4020.10**
(Rev, October 2023)

- Enter Gross Routine Services Revenue on line 5, column 1, from page 4.2, column ~~11~~ *17*, line 70. Column 2 should be taken from the prior year report or financial records.

per agency request 10/18/2023 TF

- Enter Gross Ancillary Services Revenue on line 7, column 1, from page 4.2, column ~~11~~ *17* plus ~~12~~ *18*, line 170. Column 2 should be taken from the prior year report or financial records.

- Enter Deductions from Revenue on line 10, column 1, from page 4.2, column 19, line 240. Column 2 should be taken from the prior year report or financial records.

- ~~Subtract line 10 from line 5 and enter the amount on line 15.~~ *Total Lines 5 and 7, then subtract line 10 and enter the amount on Line 15.*

- ~~Total lines 5 and 10 and enter the amount on line 15.~~

- Enter Other Operating Revenue from Health Care Operations (Account 5710 - 5900) on line 20. This amount must agree with page 10.2, line 100.

- Total lines 15 and 20 and enter the result on line 25.

- Enter Skilled Nursing Care expenses on line 30 from page 10.1, column 10, line 105.

- Enter Intermediate Care expenses on line 35 from page 10.1, column 10, line 110.

- Enter Mentally Disordered Care expenses on line 40 from page 10.1, column 10, line 115.

- Enter Developmentally Disabled Care expenses on line 45 from page 10.1, column 10, line 120.

- Enter Sub-Acute Care expenses on line 50 from page 10.1, column 10, line 125.

- Enter Sub-Acute Care - Pediatric expenses on line 51 from page 10.1, column 10, line 126.

- Enter Transitional Inpatient Care expenses on line 53 from page 10.1, column 10, line 128.

- Enter Hospice Inpatient Care expenses on line 55 from page 10.1, column 10, line 130.

- Enter Other Routine Services expenses on line 60 from page 10.1, column 10, line 135.

- Total lines 30 through 60 and enter the result on line 65.

- Enter Patient Supplies expenses on line 70, from page 10.1, column 10, line 75.

- Enter Specialized Support Surfaces expenses on line 72, from page 10.1, column 10, line 77.
- Enter Physical Therapy expenses on line 75, from page 10.1, column 10, line 80.
- Enter Respiratory Therapy expenses on line 76, from page 10.1, column 10, line 81.
- Enter Occupational Therapy expenses on line 77, from page 10.1, column 10, line 82.
- Enter Speech Pathology expenses on line 78, from page 10.1, column 10, line 83.
- Enter Pharmacy expenses on Line 80, from page 10.1, column 10, line 85.
- Enter Laboratory expenses on line 85 from page 10.1, column 10, line 90.
- Enter Home Health Services expenses on line 90, from page 10.1, column 10, line 95.
- Enter Other Ancillary Services expenses on line 95, from page 10.1, column 10, line 100.
- Total line 70 through 95 and enter the result on line 100.
- Enter Plant Operations and Maintenance expenses on line 105 from page 10.1, column 10, line 5.
- Enter Housekeeping expenses on line 110 from page 10.1, column 10, line 10.
- Enter Laundry and Linen expenses on line 115 from page 10.1, column 10, line 60.
- Enter Dietary expenses on line 120 from page 10.1, column 10, line 65.
- Enter Social Services expenses on line 125 from page 10.1, column 10, line 155.
- Enter Activities expenses on line 130 from page 10.1, column 10, line 160.
- Enter Inservice Education - Nursing expenses on line 135 from page 10.1, column 10, line 170.
- Enter Administration expenses on line 140 from page 10.1, column 10, line 165.
- Total line 105 through 140 and enter the results on line 145.
- Enter Depreciation and Amortization expenses on line 155 from page 10.1, column 10, sum of lines 15, 20, 25, and 30.

- Enter Leases and Rentals expenses on line 160 from page 10.1, column 10, line 35.
- Enter Property Taxes expense on line 165 from page 10.1, column 10, line 40.
- Enter Property Insurance expense on line 170 from page 10.1, column 10, line 45.
- Enter Interest - Property, Plant, and Equipment expense on line 175 from page 10.1, column 10, line 50.
- Total lines 155 through 175 and enter the result on line 180.
- Enter Interest - Other expense on line 185 from page 10.1, column 10, line 55.
- Enter Provision for Bad Debts expense on line 190 from page 10.1, column 10, line 70.
- Total lines 185 and 190 and enter the result on line 195.
- Total lines 65, 100, 145, 180, and 195 and enter the result on line 200.
- Subtract line 200 from line 25 and enter the result on line 205.
- Enter the net of the Nonhealth Care Revenue and Expenses (Account 9100) on line 210.
- Total lines 205 and 210 and enter the result on line 215.
- Enter Current Income Taxes (Account 9200) on line 220. A facility which is a division or other unit of a larger organization must include its proportionate share of income taxes, even if the facility had a net loss.
- Enter Deferred Income Taxes (Account 9200) on line 225.
- Total lines 220 and 225 and enter the result on line 230.
- Deduct line 230 from line 215 and enter the result on line 235.
- Enter Extraordinary Items (Account 9300) on lines 240 and 245. Enter extraordinary revenue items as bracketed figures. All extraordinary items must be explained in the space provided. Normally, extraordinary items must be unusual in nature, infrequent in occurrence, and material in amount.
- Total lines 240 and 245 and enter the result on line 250.
- Subtract line 250 from line 235 and enter the result on line 255.

For any charity provided during the report period:

- Enter forgone charges at full established rates on line 260.
- Enter on line 265 the total number of charity days related to forgone charges previously reported on line 260.

Page 1 - General Information and Certification

4020.21
(Rev. October 2023)

per agency request 10/18/2023 TH

- Enter the complete legal name of the facility in box 1.
- Enter the complete nine-digit State facility number in box 2. This number may be obtained from the top right-hand corner of the license issued by the Department of Health Services.
- Enter the complete nine-digit Medi-Cal provider number in box 3. This number will be found on the Medi-Cal provider agreement.
- If doing business under another name, enter that name in box 4. If the name is the same as the legal name, also enter the legal name here.
- Enter the facility's business telephone number in box 5.
- Enter the street address of the facility in box 6.
- Enter the city in which the facility is located in box 7.
- Enter in box 8 the zip code related to the street address of the facility.
- If the mailing address is different from the street address, enter the mailing address or P.O. Box in box 9, the city in box 10, and the zip code in box 11.
- Enter the name of the administrator of the facility in box 12. *If the administrator received compensation from the facility during the current reporting period, see instructions for Page 10.4 and complete "Salary Information for Owners Operators, Related Parties, Administrators, Assistant Administrators, and Board Members", as required.*
- Enter in box 13 the name of the person to contact who can answer questions concerning the report.
- Enter the business telephone number of the contact person in box 14, as well as the individual's mailing address or P.O. Box number in box 15, the city in box 16, the state in box 17 (please use the standard two-letter state abbreviation), and the zip code in box 18.
- If the facility has changed names since submitting the previous report, enter previous name in box 19, and the date of the change in box 20.

- If the facility has changed license numbers since submitting the previous report, enter the previous State facility number in box 21, and the date of the change in box 22.
- If the Medi-Cal provider number has changed since the previous report was submitted, enter the previous Medi-Cal provider number in box 23, and the date of the change in box 24.
- Enter in box 25 the beginning date of the reporting period and enter in box 26 the ending date of the reporting period.

Reporting Forms **4100**
(Rev. October 2023)

per agency request 10/18/2023 TH

Pages 4.1 and 4.2, Revise to accommodate new payer categories.

4.1

FACILITY PATIENT DAYS BY PAYER

Facility D.B.A. Name _____ Report Period End _____

Line No.	PATIENT (Census) DAYS	(1) Medicare Fee For Service	(2) ~~Medi-Cal~~ Medicare Managed Care	(3) ~~Self-Pay~~ Medi-Cal Fee For Service	(4) ~~Managed Care~~ Medi-Cal Managed Care	(5) ~~Other Payers~~ Commercial Coverage Fee For Service	(6) ~~Total~~ Commercial Coverage Managed Care	(7) Self Pay	(8) Other Payers	(9) Total (Cols 1-8)
	Routine Services:									
5	Skilled Nursing Care									
10	Intermediate Care									
15	Mentally Disordered Care									
20	Developmentally Disabled Care									
25	Sub-Acute Care									
30	Sub-Acute Care - Pediatric									
35	Transitional Inpatient Care									
40	Hospice Inpatient Care									
45	Other Routine Services									
70	Subtotal (Lines 5 through 45)									

4.3 **FACILITY REVENUE INFORMATION**

Facility D.B.A. Name | Report Period End

Line No.	GROSS REVENUE	Account Number	Medicare: (1) Inpatient	Medicare: (2) Outpatient	Medi-Cal: (3) Inpatient	Medi-Cal: (4) Outpatient	Medi-Cal: (5) Inpatient	Medi-Cal: (6) Outpatient	Medi-Cal: (7) Inpatient	Medi-Cal: (8) Outpatient	Commercial Coverage: (9) Inpatient	Commercial Coverage: (10) Outpatient	Commercial Coverage: (11) Inpatient	Commercial Coverage: (12) Outpatient	Line No.
	Routine Services:														
5	Skilled Nursing Care	3100													5
10	Intermediate Care	3200													10
15	Mentally Disordered Care	3300													15
20	Developmentally Disabled Care	3400													20
25	Sub-Acute Care	3500													25
30	Sub-Acute Care - Pediatric	3520													30
35	Transitional Inpatient Care	3540													35
40	Hospice Inpatient Care	3600													40
45	Other Routine Services	3900													45
70	Subtotal (Lines 5 through 45)														70
	Ancillary Services:														
105	Patient Supplies	4100													105
110	Specialized Support Services	4150													110
115	Physical Therapy	4200													115
120	Respiratory Therapy	4220													120
125	Occupational Therapy	4250													125
130	Speech Pathology	4280													130
135	Pharmacy	4300													135
140	Laboratory	4400													140
145	Home Health Services	4600													145
150	Other Ancillary Services	4900													150
170	Subtotal Lines 105 through 150														170
175	Total Gross Revenue (Line 70 + 170)														175

4.3 (1)

Line No.	DEDUCTIONS FROM REVENUE	Account Number	Medicare: (1) Inpatient	Medicare: (2) Outpatient	Medi-Cal: (3) Inpatient	Medi-Cal: (4) Outpatient	Medi-Cal: (5) Inpatient	Medi-Cal: (6) Outpatient	Medi-Cal: (7) Inpatient	Medi-Cal: (8) Outpatient	Commercial Coverage: (9) Inpatient	Commercial Coverage: (10) Outpatient	Commercial Coverage: (11) Inpatient	Commercial Coverage: (12) Outpatient	Line No.
205	Charity Adjustments	5100													205
210	Administrative Adjustments	5200													210
215	Contractual Adjustments - Medicare	5310													215
220	Contractual Adjustments - Medi-Cal	5320													220
222	Contractual Adjustments - Commercial Coverage	5330													222
225	Contractual Adjustments - Other	5340													225
230	Other Deductions from Revenue	5400													230
240	Total Deductions from Revenue														240
250	Net Patient Revenue (line 175 - 240)														250

4.3 **FACILITY REVENUE INFORMATION**

Facility D.B.A. Name | Report Period End

Line No.	GROSS REVENUE	Account Number	Self-Pay: (13) Inpatient	Self-Pay: (14) Outpatient	Other Payers: (15) Inpatient	Other Payers: (16) Outpatient	Total Gross Revenue: (17) Inpatient	Total Gross Revenue: (18) Outpatient	Total Gross Revenue: (19) Total	Line No.
	Routine Services:									
5	Skilled Nursing Care	3100								5
10	Intermediate Care	3200								10
15	Mentally Disordered Care	3300								15
20	Developmentally Disabled Care	3400								20
25	Sub-Acute Care	3500								25
30	Sub-Acute Care - Pediatric	3520								30
35	Transitional Inpatient Care	3540								35
40	Hospice Inpatient Care	3600								40
45	Other Routine Services	3900								45
70	Subtotal (Lines 5 through 45)									70
	Ancillary Services:									
105	Patient Supplies	4100								105
110	Specialized Support Services	4150								110
115	Physical Therapy	4200								115
120	Respiratory Therapy	4220								120
125	Occupational Therapy	4250								125
130	Speech Pathology	4280								130
135	Pharmacy	4300								135
140	Laboratory	4400								140
145	Home Health Services	4600								145
150	Other Ancillary Services	4900								150
170	Subtotal Lines 105 through 150									170
175	Total Gross Revenue (Line 70 + 170)									175

4.3 (1)

Line No.	DEDUCTIONS FROM REVENUE	Account Number	Self-Pay: (13) Inpatient	Self-Pay: (14) Outpatient	Other Payers: (15) Inpatient	Other Payers: (16) Outpatient	Total Deductions from Revenue: (17) Inpatient	Total Deductions from Revenue: (18) Outpatient	Total Deductions from Revenue: (19) Total	Line No.
205	Charity Adjustments	5100								205
210	Administrative Adjustments	5200								210
215	Contractual Adjustments - Medicare	5310								215
220	Contractual Adjustments - Medi-Cal	5320								220
222	Contractual Adjustments - Commercial Coverage	5330								222
225	Contractual Adjustments - Other	5340								225
230	Other Deductions from Revenue	5400								230
240	Total Deductions from Revenue									240
250	Net Patient Revenue (line 175 - 240)									250

Appendix B

The following terms have been added to Appendix B – "Glossary":

Page B-25

Fee-for-Service

A health care plan in which beneficiaries can see any provider who accepts their coverage, and providers are reimbursed for each individual service or visit.

Page B-41

Managed Care

A health care plan or insurer with which providers contract with health plans and insurers to deliver benefits to members in exchange for a monthly member fee.

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

RULEMAKING FILE
(LTC Financial Reporting – Expanding Managed Care Payer Categories)

Item 10:

DOCUMENTS INCORPORATED BY REFERENCE – *INSTRUCTIONS AND SPECIFICATIONS FOR DEVELOPING APPROVED SOFTWARE TO PREPARE THE CALIFORNIA LONG-TERM CARE FACILITY INTEGRATED DISCLOSURE & MEDI-CAL COST REPORT*

STATE OF CALIFORNIA

~~OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT~~

DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

INSTRUCTIONS AND SPECIFICATIONS FOR DEVELOPING APPROVED SOFTWARE TO PREPARE THE CALIFORNIA LONG-TERM CARE FACILITY INTEGRATED DISCLOSURE & MEDI-CAL COST REPORT

Applicable for Report Periods
Ending after on or after ~~January 1, 2020~~ *January 1, 2024*

STATE OF CALIFORNIA
~~OFFICE OF STATEWIDE HEALTH PLANNING & DEVELOPMENT~~
DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION

INSTRUCTIONS AND SPECIFICATIONS FOR DEVELOPING APPROVED SOFTWARE TO PREPARE THE CALIFORNIA LONG-TERM CARE FACILITY INTEGRATED DISCLOSURE & MEDI-CAL COST REPORT FOR ELECTRONIC SUBMISSION

Applicable for Report Periods
Ending on or after ~~January 1, 2020~~ *January 1, 2024*

TABLE OF CONTENTS

~~Office of Statewide Health Planning and Development~~
Department of Health Care Access and Information
Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report
SUMMARY OF CHANGES
for report periods ended on or after ~~January 1, 2020~~ *January 1, 2024*

The Office of Statewide Health Planning and Development, the "Office" and OSHPD references have been replaced with the Department of Health Care Access and Information, the "Department" and HCAI throughout this document.

FILE RECORD FORMAT SPECIFICATIONS

The version number has been changed to ~~"44A"~~ *"48A"* page E-2.

TEST CASE DATA – COMPLETED REPORT FOR FICTITIOUS FACILITY

There are changes in this section indicated in red strikeout and blue italics format.

LISTING OF THE TEST CASE DATA

There are changes in this section indicated in red strikeout and blue italics format.

EDIT SPECIFICATIONS

There are changes in Section I, Edit Specifications, indicated in red strikeout and blue italics format.

A. INTRODUCTION

This package provides vendors and long-term care (LTC) facilities with the requirements for obtaining the ~~Office of Statewide Health Planning and Development's (OSHPD's)~~ *Department of Health Care Access and Information's (HCAI's)* approval of software to prepare the Long-term Care Facility Integrated Disclosure and Medi-Cal Cost Report (disclosure report) as an electronic file. The requirements include technical specifications, including editing criteria and a test case for formatting the report data. They are neither computer programs nor detailed design specifications for developing the report preparation software to assist in the preparation of the reports. These specifications are limited to the basic requirements the software must meet to obtain ~~OSHPD~~*HCAI*'s approval.

General information, authorization procedures, file format specifications, and test case are provided in this document. Samples of the various forms required for automated reporting are also included. Proper use of these forms will greatly assist the testing process. ~~OSHPD~~*HCAI* will return test files that do not have properly prepared forms. Questions, comments, and suggestions regarding this package should be directed to:

Lexie Bloyd, Supervisor
~~Office of Statewide Health Planning and Development~~
Department of Health Care Access and Information
Accounting and Reporting Systems Section
Long-Term Care Financial Data Unit
2020 West El Camino Avenue, Suite 1100
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Telephone: (916) 326-3833
~~Fax: (916) 322-1442~~
E-mail: lexie.bloyd@~~oshpd~~*hcai*.ca.gov

B. GENERAL INFORMATION

1. Only those vendors and facilities who have received authorization from the ~~Office~~*Department* may distribute and/or use software to prepare ~~Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Reports (~~disclosure reports~~)~~.

2. To obtain authorization, the included test case report must be automated in accordance with ~~OSHPD~~*HCAI*'s specifications and submitted to ~~OSHPD~~*HCAI* for verification. Upon ~~OSHPD~~*HCAI*'s written authorization, the vendor or facility may begin using the software for automated reporting. A "Request for Approval of Software to Prepare the Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report" form (see page J-2) and a "Transmittal and Certification Form" (see page J-5) are required for submission of the test file.

3. Automated reports submitted using unauthorized or non-current software will be rejected.

4. Only completely automated reports will be accepted. ~~OSHPD~~*HCAI* will not accept a combination of manually completed report pages and automated pages.

5. ~~OSHPD~~*HCAI* will reject any automated report that does not comply with the specifications or fails to meet normal reporting requirements as specified in ~~OSHPD~~*HCAI*'s *Accounting and Reporting Manual for California Long-Term Care Facilities*, Second Edition *(LTC Manual)*. It is the responsibility of the facility to submit the automated report correctly on or before the report due date (allowing for approved extensions). Rejection of the automated report for failure to meet any of the above does not constitute acceptable cause to grant an extension of the due date.

6. All automated reports must be completed in accordance with ~~OSHPD's~~ *the LTC Manual* ~~*Accounting and Reporting Manual for California Long-Term Care Facilities,* Second Edition.~~ A manual can be downloaded from ~~OSHPD~~*HCAI*'s website.

7. Once a vendor's software has been approved by ~~OSHPD~~*HCAI*, facilities and report preparers who obtain the software and use it without modification are extended the authorization to submit automated reports.

8. On request, ~~OSHPD~~*HCAI* can provide a list of those vendors that have developed software packages that meet ~~OSHPD~~*HCAI*'s automated reporting requirements.

9. For vendors, facilities, and report preparers to retain authorization to distribute and/or use software to prepare disclosure reports, their software must comply with these specifications.

C. AUTHORIZATION PROCEDURES

1. To obtain authorization to distribute and/or use software to prepare ~~Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Reports (~~disclosure reports~~)~~, the vendor must develop software according to ~~OSHPD~~*HCAI*'s specifications.

2. A test case is included in this document to determine if the record and field specifications have been met. The test case consists of a completed report for a fictitious LTC facility. The test report attempts to test as many fields on the report as possible. Consequently, it will contain a number of "warning" errors as defined in Section I -- the test case does not represent a "typical" report. A test report must be prepared and forwarded to ~~OSHPD~~*HCAI* for review and acceptance before authorization is granted.

3. The format specifications and test case materials are contained in the following sections:

   Section E. -- Record Specifications

   Section F. -- Field Definitions

   Section G. -- Test Case -- Completed Report for Fictitious Facility

   Section H. -- Listing of the Test Case Data

   Section I. -- Edit Specifications

   Section J. -- Automated Reporting Forms

4. The edit specifications in Section I are categorized in three areas: 1) software completed, 2) fatal edits, and 3) warning edits. To be considered approved, reporting software must incorporate all three categories.

5. The test file must be labeled "TEST" with the filename, LTC facility name, ~~OSHPD~~*HCAI* ID number, report period, and total record count.

6. Completed test cases along with a form (Section J) requesting the ~~Office~~*Department*'s approval **should be sent via email attachment to lexie.bloyd@~~oshpd~~*hcai*.ca.gov.**

   The authorization request form must include the vendor name, address, telephone number and the name of a contact person.

7. ~~OSHPD~~*HCAI*'s approval process will be as timely as possible. However, the test case must be submitted as far in advance of the reporting due date as possible to allow for the approval process. It may take more than one test cycle to resolve any discrepancies.

8. After the test case is approved, the vendor must submit a copy of the Report Transmittal and Certification Form via email to the address given in Step #6.

D. TECHNICAL REQUIREMENTS

1. The test file must contain only one file for one ~~LTC Facility Integrated Disclosure and Medi-Cal Cost Report~~ *disclosure report*.

2. All record formats are a maximum length of 250 characters in standard ASCII character coding with return/line feed delimiters between records. The file is not required to be sorted in any specific sequence except that the header record must be the first record in the file.

3. All alphanumeric fields are left-justified and uppercase.

4. All numeric columns are right-justified and left-zero filled. All numeric values on the ~~LTC Facility Integrated Disclosure and Medi-Cal Cost Report~~ *disclosure report* are reported in ten (10) digit fields.

5. All negative numbers in numeric fields must contain the sign in the right-most digit position. For example, a field with the negative value having the right-most value of -0, then the character representation is "}"; -1 is "J"; -2 is "K"; and -9 is "R". Leading hyphens are not allowed to indicate negative numbers.

6. The actual field sizes in the ~~OSHPD~~*HCAI*'s data base are shown in the Section F, Field Definitions. It is recommended that reporting software support the actual field sizes to avoid reporting errors.

7. The vendor's software may create filenames or let the report preparers create their own filenames. The filename must appear on the "Report Transmittal and Certification" form. The filename should be unique so the file can be easily identified (i.e. contain the ~~OSHPD~~*HCAI* ID and report period end date).

8. Vendor software must allow report preparers to generate a facsimile (copy) of their completed report. The facsimile report should not be sent by the report preparer to ~~OSHPD~~*HCAI* and is intended for the use of the report preparer to review the report prior to submission.

E. FILE RECORD SPECIFICATIONS

This section describes the three record formats required for preparing the ~~Long-Term Care Facility Integrated Disclosure and Medi-Cal Cost Report~~ *disclosure report*. The three formats are:

1.	Header Record	»	Defines the facility, report period, and software version
2.	Alphanumeric Record	»	Used for reporting alphanumeric fields
3.	Numeric Record	»	Used for reporting numeric fields

All record formats are a maximum length of 250 characters, in standard ASCII character coding.

The header record must be the first record in the file and there must be only one. It is used primarily to identify the facility, end of the report period, and the header record version for the cycle of the report period end date. The header record must be present and complete. ~~For report periods ending June 30, 2019 through December 30, 2019, the header record version is "42A". For the cycle of periods ending December 31, 2019, the header record version is "43A".~~ For the report cycle January 1, 202~~0~~*4* through December 31, 202~~0~~*4*, the header record version is "4~~3~~*8*A". For each subsequent cycle, the header record version increases by "1". For example:

- ~~For the report cycle January 1, 2021 through December 31, 2021, the header record version is "45A".~~
- ~~For the report cycle January 1, 2022 through December 31, 2022, the header record version is "46A".~~
- ~~For the report cycle January 1, 2023 through December 31, 2023, the header record version is "47A".~~
- *For the report cycle January 1, 2025 through December 31, 2025, the header record version is "49A".*
- *For the report cycle January 1, 2026 through December 31, 2026, the header record version is "50A".*
- *For the report cycle January 1, 2027 through December 31, 2027, the header record version is "51A".*
- *For the report cycle January 1, 2028 through December 31, 2028, the header record version is "52A".*

The other two record formats are used to record the disclosure report data. Data records need to be created for only non-blank or non-zero entries in the disclosure report. Since the report data are either text or numeric, a separate format was defined for each.

The text or "alphanumeric" format will accommodate the value for one data field. The numeric format must contain only one numerically-defined data field. The text and numeric