State of West Virginia
Department of Administration
Purchasing Division
2019 Washington Street East
Post Office Box 50130
Charleston, WV 25305-0130

Solicitation

NUMBER	PAGE
HHR13017	1

ADDRESS CORRESPONDENCE TO ATTENTION OF:

ROBERTA WAGNER
304-558-0067

VENDOR

RFQ COPY
TYPE NAME/ADDRESS HERE

SHIP TO

HEALTH AND HUMAN RESOURCES
INTERNAL CONTROL & POLICY
DEVELOPMENT
ONE DAVIS SQUARE, SUITE 401
CHARLESTON, WV
25301 304-558-7314

DATE PRINTED: 06/21/2012

BID OPENING DATE: 06/26/2012 BID OPENING TIME 01:30PM

LINE	QUANTITY	UOP	CAT. NO.	ITEM NUMBER	UNIT PRICE	AMOUNT
	ADDENDUM NO. 1					
	1. QUESTIONS AND ANSWERS ATTACHED.					
	2. ADDITIONAL TERMS & CONDITIONS ATTACHED.					
	3. ADDENDUM ACKNOWLEDGEMENT IS ATTACHED. THIS DOCUMENT SHOULD BE RETURNED AND RETURNED WITH YOUR BID. FAILURE TO SIGN AND RETURN MAY RESULT IN DISQUALIFICATION OF YOUR BID.					
	END OF ADDENDUM NO. 1					
0001	1	JB		961-20		
	PROFESSIONAL AUDITING SERVICES - CPA					
	****** THIS IS THE END OF RFQ HHR13017 ****** TOTAL:					

SIGNATURE	TELEPHONE	DATE
TITLE	FEIN	ADDRESS CHANGES TO BE NOTED ABOVE

WHEN RESPONDING TO SOLICITATION, INSERT NAME AND ADDRESS IN SPACE ABOVE LABELED 'VENDOR'

SOLICITATION NUMBER: HHR13017
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as WSH13025 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[X] Attachment of vendor questions and responses

[X] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Description of Modification to Solicitation: See attached

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ATTACHMENT A

HHR13017

ADDENDUM NO. 1

ADDITIONAL TERMS AND CONDITIONS

Various Legislative acts passed in the 2012 session require inclusion of certain provisions in all state contracts. Accordingly, this addendum will add the three provisions listed below to the solicitation and resulting contract entered into between the State of West Virginia and the vendor. In the event that the solicitation is not for construction or architectural/engineering work, sections 2 and 3 below will not apply.

1. **BACKGROUND CHECK:** In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services may require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information to submit to a fingerprint-based state and federal background inquiry through the state repository.

   After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision.

   The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

2. **SUBCONTRACTOR LIST SUBMISSION:** In accordance with W. Va. Code § 5-22-1, The apparent low bidder on a contract for the construction, alteration, decoration, painting or improvement of a new or existing building or structure valued at more than $500,000.00 shall submit a list of all subcontractors who will perform more than $25,000.00 of work on the project including labor and materials. This provision shall not apply to any other construction projects, such as highway, mine reclamation, water or sewer projects.

   a. **Required Information.** The subcontractor list shall contain the following information:

      i. Bidder's name
      ii. Name of each subcontractor
      iii. License numbers as required by W. Va. Code § 21-11-1 et. seq.

iv. Notation that no subcontractors will be used if the bidder will perform the work

b. **Submission.** The completed subcontractor list shall be provided to the Purchasing Division within one business day of the opening of bids for review. Failure to submit the subcontractor list within one business day after the deadline for submitting bids shall result in disqualification of the bid.

c. **Substitution of Subcontractor.** Written approval must be obtained from the Purchasing Division before any subcontractor substitution is permitted. Substitutions are not permitted unless:

i. The subcontractor listed in the original bid has filed for bankruptcy;
ii. The subcontractor in the original bid has been debarred or suspended; or
iii. The contractor certifies in writing that the subcontractor listed in the original bill fails, is unable, or refuses to perform his subcontract.

3. **GREEN BUILDINGS MINIMUM ENERGY STANDARDS:** In accordance with § 22-29-4, all new building construction projects of public agencies that have not entered the schematic design phase prior to July 1, 2012, or any building construction project receiving state grant funds and appropriations, including public schools, that have not entered the schematic design phase prior to July 1, 2012, shall be designed and constructed complying with the ICC International Energy Conservation Code, adopted by the State Fire Commission, and the ANSI/ASHRAE/IESNA Standard 90.1-2007: *Provided*, That if any construction project has a commitment of federal funds to pay for a portion of such project, this provision shall only apply to the extent such standards are consistent with the federal standards.

General:

1. Please provide the prior year audit fees and manhours per facility, along with a breakdown of how many cost report audits it covers.

   A. The prior audit fees billed under HHR90057 are shown in Addendum Attachment A. As the bids were all-inclusive per engagement and were billed on completed job, man-hours per facility are not available. The costs for the additional services were incurred evenly across the seventeen audits. The seventeen audits each covered 4 years of cost reports or 8 reporting periods.

2. Please provide the listing of questions and responses from the original RFP.

   A. See Attachment B Prior Questions for HHR12070.

3. Please clarify why the RFQ was re-bid.

   A. The original RFQ was rescinded due to technical errors contained within the original RFQ.

4. Please provide a copy of the state plan in effect for the cost periods under audit.

   A. The effective state plan is included as Attachment C.

5. Are prior year audit reports and findings available for our review?

   A. The prior audit report and findings will be made available to the firm which is awarded the contract.

6. Are crosswalks normally submitted with the Cost Reports, and will they be available for our review?

   A All long term care facilities are required to submit Medicaid Grouping Reports, which includes the facility's account numbers. These will be provided to the successful firm upon the award of the contract.

7. Did all auditees also file Medicare cost reports for the periods under audit?

   A. If the auditees are certified for Medicare patients, they would be required to file Medicare cost reports. LTC-FASR's are filed as of June 30th and December 31st each year while Medicare cost reports are filed annually based on the facility's year end.

8. Have any Medicaid cost reports under audit been reopened since original submission, and are details available?

   A. Yes. Details would be made available upon award to the successful bidder as necessary.

9. During the period(s) under audit, did any of the facilities selected for audit:

   a. Undergo an ownership change, or change in professional management firms?

      A. Yes, one facility in year one of the contract did undergo a change in ownership during the audit period. Also, one facility in year one of the contract has since closed during the audit period.

   b. Acquire a facility that was previously participating in Medicare/Medicaid?

      A. Yes

   c. Experience a significant increase or decrease in its number of total beds or Medicaid certified beds? (significant >10%)

      A. One facility experienced a significant decrease in beds certified for Medicaid (Year 3 of the contract).
      One facility experienced a significant increase in beds certified for Medicaid (Year 1 of the contract).

   d. Utilize a significant number of agency nurses among its entire nursing staff (>10% of nursing staff)?

      A. In year 2, Attachment 2 of the Request for Quote, three facilities utilized a significant number of agency nurses. In year 3, Attachment 3 of the RFQ one facility utilized a significant number of agency nurses.

   e. Become a new provider under the Medicaid program (i.e., file an initial Medicaid cost report)?

      A. No.

   f. Have significant non-allowable cost centers, e.g., adult day care, assisted or independent living?

      A. In some instances, particularly involving hospital based LT facilities there are significant non-allowable costs.

   g. Have different year end's than the cost report filing periods?

      A. Yes. Several facilities have a different fiscal year end than cost reporting period.

Requirement specific:

10. Requirement #2 states that the Vendor must have on staff at least 5 CPA's licensed in West Virginia.
    h. Can this requirement be covered by subcontractor firms or must the primary vendor meet the requirement on their own? (For example, an out of state vendor using in-state subcontractors may not be licensed themselves, but the subcontractors would be)

        A. The requirement must be met by the primary vendor.

    i. If the primary vendor is required to meet the requirement, and intends to gain reciprocity in West Virginia, will documentation that the reciprocity process is initiated meet the requirement?

        A. Yes.

Page 11, #1 and #2 - #1 states that the engagements are to be in accordance with the ***attestation*** standards established by the AICPA as well as Government Auditing Standards. #2 states that upon request, the vendor is to perform financial and compliance audit engagements in accordance with standards applicable to financial audits.

  j. Please provide a sample of a prior audit report as issued, including any findings and non-compliance

      A. See response to Question # 2 Attachment B for sample audit report.

  k. Please clarify that #1 is actually under ***auditing*** standards, and not attestation standards.

      A. The RFQ requirements are not for the performance of a full standard opinion audit, therefore as shown in the prior report the engagements should be done in accordance with attestation standards of AICPA and applicable Governmental Auditing Standards.

11. Page 11, #3 states that the engagements are to incorporate a pre-engagement planning meeting. Can these meeting be via conference call or must the all be in person?

    B. The initial meeting will be in person however, it is possible that subsequent meetings may be able to be done by conference call.

12. #5, pg 12, states that the engagements shall include up to 8 semi-annual LTC-FASR's. Please clarify the following:
    a. Will each semi-annual cost report require its own opinion? Or will the entire 8 cost reports under audit for each facility be considered one population with one audit opinion?

        i. There should be one opinion for each facility, regardless of the number of cost reports involved.

b. For the first year, it was indicated that the reports would cover the periods June 2007 through December 2010 filings. Will the second year cover the next rolling time frame? (June 2008 – December 2011) and so forth?

   i. The first year of the contract would cover the June 2008 through December 2011 filings. The second year would cover the next rolling time frame (June 2009 through December 2012) and the third year would cover June 2010 through 2013.

c. Are the second and third years expected to have the same number of cost report audits?

   i. There are seventeen facilities for each year of the contract. With the exception of Summers County ARH, each facility has eight cost reports in the audit period. Summers County has six.

13. **Mandatory Requirement – Vendor Experience/Capabilities: #2** – CPA Mobility became effective in West Virginia June 5, 2008. If our staff are licensed in other states and they meet the requirements to have practice privileges in West Virginia in accordance with the Mobility legislation, would the requirement to have "at least five (5) staff hold CPA certification valid in the State of West Virginia" be met?

    i. Yes.

14. **Scope of Work – Mandatory Requirements: #18** – For purposes of completing the cost sheets, for each provider, are we to propose a <u>per</u> engagement fee? Should we also assume for purposes of pricing that one (1) engagement equals eight (8) cost reporting periods?

    i. Yes. Bids should be on an all-inclusive per engagement basis. There are seventeen facilities shown that will be under audit and each facility engagement will cover that facility's eight cost reporting periods.

SIGN IN SHEET

Page 1 of ____

Request for Quotation No. HHR13017

PLEASE PRINT

Date:

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FIRM & REPRESENTATIVE NAME	MAILING ADDRESS	TELEPHONE & FAX NUMBERS
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Rep: Bryan Rosen		TOLL FREE
Email Address: bryan.d.rosen@wv.gov		FAX
Company: DHHR		PHONE 558-2020
Rep: Jeff Bush		TOLL FREE
Email Address: jeffrey.l.bush@wv.gov		FAX
Company: DHHR		PHONE (304) 558-0951
Rep: Debbie Zegeer		TOLL FREE
Email Address: Deborah.K.Zegeer@wv.gov		FAX
Company: Hayflich & Steinberg		PHONE 304-697-5700
Rep: Richard A. Eskins		TOLL FREE
Email Address: ESKINS@HAYFLICH.NET		FAX 304-697-5704
Company: Suttle + Stalnaker, PLLC		PHONE 304-343-4126
Rep: Chris Lambert		TOLL FREE
Email Address: cslambert@suttlecpas.com		FAX 304-343-8008

SIGN IN SHEET

Request for Quotation No. HHR13017

PLEASE PRINT

Date:

* PLEASE BE SURE TO PRINT LEGIBLY - IF POSSIBLE, LEAVE A BUSINESS CARD

FIRM & REPRESENTATIVE NAME	MAILING ADDRESS	TELEPHONE & FAX NUMBERS
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Company: Smith Cochran & Hicks PLLC		PHONE 304-345-1151
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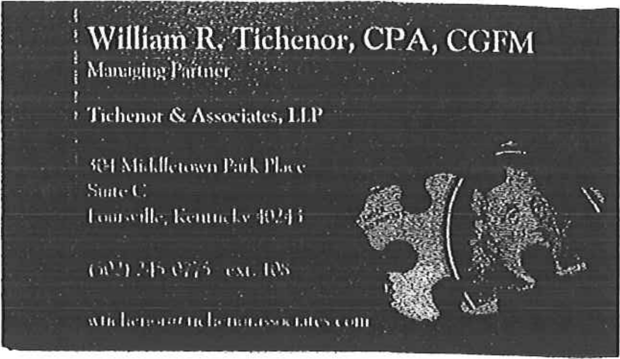

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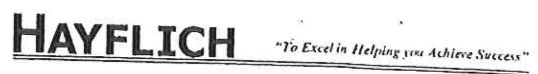

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HHR90057 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORT

ALL-INCLUSIVE COST SHEET

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

	Facility	All-Inclusive Per Engagement Cost
1.	Clarksburg Nursing & Rehabilitation Center	$8,850
2.	Fayette Nursing Rehabilitation Center	8,850
3.	E.A. Hawse Nursing & Rehabilitation Center	8,850
4.	Lincoln Nursing & Rehabilitation Center	8,850
5.	Cameron Nursing & Rehabilitation Center	8,850
6.	McDowell Nursing & Rehabilitation Center	8,850
7.	Summers Nursing & Rehabilitation Center	8,850
8.	Wayne Nursing & Rehabilitation Center	8,850
9.	Webster Nursing & Rehabilitation Center	8,850
10.	Wyoming Nursing & Rehabilitation Center	8,850
11.	Mercer Nursing & Rehabilitation Center	8,850
12.	The Brier	8,950
13.	Valley Haven Geriatric Center	8,950
14.	Valley View Nursing Home	8,950
15.	Hampshire Memorial Hospital	9,250
16.	Grafton City Hospital	9,250
17.	Huntington Health & Rehabilitation Center	9,350
	Total Cost for Standard Engagements	$152,050

HOURLY RATE FOR ADDITIONAL SERVICES

Classification	Maximum Hours	Hourly Rate	Total
Partner/Member	15	$100	$ 1,500
Manager	30	85	2,550
Supervisor	75	70	5,250
Staff	150	50	7,500
Clerical	50	25	1,250

Total Cost For Additional Services $18,050

SUMMARY OF ALL COSTS

Total Cost for Standard Engagements	$152,050
Total Cost for Additional Services	18,050
Total Contract Cost	$170,100

Evaluation of Bids. Cost evaluations will be based on the total contract cost and the vendor's documentation of experience & capabilities. It is preferred that all vendors complete the above pricing page rather than submitting a separate quote.

HHR90057 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
OFFICE OF ACCOUNTABILITY AND MANAGEMENT REPORT

ALL-INCLUSIVE COST SHEET

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

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SUMMARY OF ALL COSTS

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Total Cost for Additional Services	18,050
Total Contract Cost	$170,100

Evaluation of Bids. Cost evaluations will be based on the total contract cost and the vendor's documentation of experience & capabilities. It is preferred that all vendors complete the above pricing page rather than submitting a separate quote

HHR 13017 ADDENDUM B3-QUESTION # 2

WV DHHR-OAMR RESPONSES TO WRITTEN VENDOR QUESTIONS RFQ HHR12070

1) How many cost report periods and six-month periods are there to be audited for the 17 facilities?

   A. WV DHHR can go back five years to conduct LT-FASR audits. It is anticipated that we would assign the past 3 to five years of cost reporting comprised of two six month cost reporting periods each year. Therefore it is possible that from 6 to 10 cost reporting periods would be requested to be audited for each of the 17 facilities.

2) Do you know where the financial records are maintained for each facility (facility and/or home office)?

   A. See Q & A Supplemental response "A" for general locations of facilities or home offices. Regardless of location, it is the policy of OAMR to give the Providers (10 business days) to provide requested audit information (unless reasonable extension of time is expressly approved by OAMR, due to significant circumstances). Failure by a facility or home office to respond to auditor's request for information will result in a full disallowance of any amounts unable to be corroborated as a result of their lack of response.

3) Where is the office located for the financial records for the audit of the home office costs?

   A. See Q & A Supplemental response "A" for general locations.

4) Could you have someone provide a copy of the last audit report for each of the facilities and home office? I need the reports to determine if there are any significant and/or unusual findings noted during the audit.

   A. As the past audit reports are not "public information" OAMR will not release them at this time, however, they are readily available and will be immediately shared with the successful bidder upon award of the contract. However, a de-identified basic audit report has been provided in Q & A Supplemental Response "B" for vendor information to illustrate the attestation engagement type of audit report that is required. The OAMR will expect that the successful vendor will prepare a report with the following elements for each of the 17 facility audits :

   - Independent Accountants' Examination Report
   - Report on Internal Control and Compliance in Accordance with Government Auditing Standards
   - Schedule of Findings and Recommendations

5) Is OAMR aware of any issues occurring or adjustments made to the cost report periods that will be audited for any of the 17 facilities?

   A. OAMR is not aware of any issues occurring or adjustments made to the cost report periods that will be audited for any of the 17 facilities in Year 1. During the option Year 3 there are currently two facilities that have audit issues and/or appeals pending however, it is anticipated that those issues will be fully resolved by the time audit work for Year 3 would commence and assuming that renewal of Option Year 3 would be exercised by OAMR.

6) Can you identify which of the 17 facilities have a home office?

   A. See Q & A Supplemental response "A".

7) Can you identify which of the 17 facilities are hospital-based?

   A. See Q & A Supplemental response "A".

ADDENDUM B-QUESTION # 2

8) Which is the correct zip code for submission of the bid, 25311 or 25305-0130?
   A. The correct zip code is 25305-0130.

9) What is the Department of Administration – Purchasing Division's office schedule during the holidays for incoming package deliveries?

   A. The schedule is irrelevant as their schedule during the holiday season does not impact processing of the RFQ.

10) When does DHHR anticipate awarding the contract?

    A. It is difficult to give an exact date however it is anticipated within our budget that this encumbrance would begin approximately February, 2012.

11) Can technical and cost information be included in the same proposal? Or would you prefer that technical and cost information be in separate proposal volumes?

    A. This is an RFQ and not an RFP therefore, both the technical and the cost response should be included as part of the same submission package.

12) Mandatory Requirement – Vendor Experience/Capabilities: #2 – CPA Mobility became effective in West Virginia June 5, 2008. If our staff are licensed in other states and they meet the requirements to have practice privileges in West Virginia in accordance with the Mobility legislation, would the requirement to have "at least five (5) staff hold CPA certification valid in the State of West Virginia" be met?

    A. Yes. OAMR would recognize the right to practice in West Virginia for any CPA meeting the requirements of W. Va. Code 30-9-16.

13) Mandatory Requirement – Vendor Experience/Capabilities: #3 & 4 – What does DHHR mean by "samples of work"?

    A. Respondent could submit listing or give examples of ways they have provided cost report training or give a sample syllabus of content of training they offer.

14) Scope of Work – Mandatory Requirements: #3 – We understand OAMR will perform desk reviews prior to any field audits. Will the contractor be given the desk review file for review to help with audit planning?

    A. Yes. The desk review file may be relevant to the audits in some cases. As such if information from them are needed it will be made available either by documentary evidence or through interaction with the OAMR staff as necessary.

15) Scope of Work – Mandatory Requirements: #4 – This requirement states "[t]he procedures for each engagement are to include, at a minimum, the procedures outlined in the OAMR Audit Guide." May a bidder propose alternative procedures to meet the audit objectives?

    A. Yes. If alternative procedures would result in meeting the objectives and assertions of the audit program then they may be utilized upon approval by OAMR.

16) Scope of Work – Mandatory Requirements: #11 – What is the percentage of contractor performed examinations that are appealed and what is the average number of hours a contractor would expect to spend per appeal?

ADDENDUM B-QUESTION # 2

A. Approximately 3%-5% of the exams typically may result in an appeal. The amount of time a contractor would be required to spend in an appeal would depend on the issues involved. The involvement would most likely consist of response to inquiries and other preparation to assist WV Medicaid Legal department and OAMR to defend decisions of cost disallowance that may be challenged in an appeal by a provider.

Much of this preparation may be possible by conference call. OAMR will do everything possible to minimize the contractor involvement in the process and limit travel costs.

17) Scope of Work – Mandatory Requirements: #17 – This requires all draft reports to be submitted no later than 90 days before the contract expiration date. Is the "contract expiration date" the last day of each contract year (the base year and each of the two renewal years)?

A. Yes. This mandatory was put in the RFQ to make it clear to the contractor that all field work and reporting work must be completed within the 12-month contract period. The 90-day requirement is to allow OAMR adequate time to quality review and approve a clean final draft of the audit report prior to expiration of the contract so we may be able to approve final payment.

18) Scope of Work – Mandatory Requirements: #18 – The requirement says "[i]n the event that less than eight (8) LTC-FASRs cost reporting periods are to be examined in an engagement, the vendor is to adjust the per engagement fee to accommodate the reduction in work accordingly." Does this mean that the "All-inclusive Per Engagement Cost" to be included on Attachments 1-3 is to assume that all engagements will include eight (8) LTC-FASR cost reporting periods?

A. Yes. There is a possibility that this contract will be renewed for two periods after it is awarded. The language regarding six (6) to ten (10) is included so that in the event the contract is renewed OAMR may specify the number of LTC-FASRs to be included in the renewal. For the purposes of this year's contract, however, the number of LTC-FASRs has been specified as eight (8). The fee should be based on the eight (8) LTC-FASR periods specified

19) **Price Quotations – pg. 19** – Attachment #1 does not list locations or the number of LTC-FASRs to be included in the engagement. Will that be made available?

A. Yes. See Supplement A.

20) Does each of the 17 facilities include eight cost reports, which would span four years?

A. Yes.

21) Vendor Experience/Capabilities #3 – Can you give an example of the type of samples of work to demonstrate expertise you would like to see submitted?

A. Respondent could submit listing or give examples of types or specific audit engagement clients that would demonstrate specific expertise.

22) Vendor Experience/Capabilities #4 – Can you give an example of the type of samples of work to demonstrate proficiency you would like to see submitted?

A. Respondent could submit listing or give examples of types or specific audit engagement clients that would demonstrate specific proficiency.

ADDENDUM B-QUESTION # 2

23) Scope of Work #1-3 – Can you provide a redacted example of the report(s) you are requesting?

A. Yes. See Supplement B.

24) Scope of Work #6 – Is it expected or normal that the auditors visit the home offices of chain facilities?

A. In most cases it is not expected or the norm that the auditor would have to visit the home office. Most time our internal staff is able to obtain necessary audit information through correspondence and/or conference call or by visit to the local (West Virginia) facility. OAMR would make a determination if an onsite visit were necessary.

25) Scope of Work #11 – How common is it for providers to appeal and what is the general timeframe for contractor CPAs' involvement?

A. See Answer to Question #16 on appeals and involvement of contractor.

26) Audit Guide – Will OAMR personnel perform any of the procedures?

A. OAMR staff and management will be available to provide guidance and direction relative to the provider or the OAMR Audit Program on a limited basis however, the successful contractor is expected to complete field work and reporting without expectation of reliance on OAMR for staffing needs to complete work.

27) Please provide a Facility list (pages 21 – 23 of the RFQ) indicating which locations are part of a chain of facilities and the name and location of the parent or home offices for each along with their ownership structure.

A. See Supplement A.

28) For chains with home offices outside of West Virginia, could you provide an estimate of the percentage of work to be done at the home office compared to the percentage of work to be done at the facility.

A. Most of the audit field work information required of the home office should be able to be done through phone or email correspondence with the home office and direct field work at the West Virginia facility/facilities.

29) Could you please provide the prior year total billings for the previous contract?

A. The previous contract billings stretched beyond last year and were based on completed audit reports rather than hours billed however, for year one of the previous contract amounts billed totaled about $170,000.

30) Could you please provide any additional scope of work changes for the previous contract?

A. There were no changes impacting the scope of work for the previous contract.

ADDENDUM B-QUESTION # 2

31) Please provide a copy of the prior year attestation examination reports, related findings, and any other required communications letters issued on these entities from the prior period.

A. See Supplement B.

HHR13017 ADDENDUM ATTACHMENT B1

Q & A SUPPLEMENTAL RESPONSE "B"

FINANCIAL & STATISTICAL REPORTS FOR NURSING HOME

SIX MONTH PERIODS ENDED JUNE 30, 2004, DECEMBER 31, 2004, JUNE 30, 2005, DECEMBER 31, 2005, JUNE 30, 2006, DECEMBER 31, 2006, JUNE 30, 2007, AND DECEMBER 31, 2007

AND

INDEPENDENT ACCOUNTANTS' EXAMINATION REPORT

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HHR13017 ADDENDUM ATTACHMENT B1

INDEPENDENT ACCOUNTANTS' EXAMINATION REPORT

Department of Health and Human Resources
Office of Accountability and Management Reporting
One Davis Square
Suite 304
Charleston, West Virginia 25301

We have examined the financial and statistical information included in the West Virginia Department of Health and Human Resources Financial & Statistical Reports for Nursing Homes of
s of and for the six month periods ended June 30, 2004, December 31, 2004, June 30, 2005, December 31, 2005, June 30, 2006, December 31, 2006, June 30, 2007, and December 31, 2007. The financial and statistical information included in the West Virginia Department of Health and Human Resources Financial & Statistical Reports is the responsibility of the Provider's management. Our responsibility is to express an opinion on the financial and statistical information included in the West Virginia Department of Health and Human Resources Financial & Statistical Reports based on our examinations.

Our examinations were conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and the West Virginia Department of Health and Human Resources, Office of Accountability and Management Reporting Audit Guide for Long Term Care Facilities, Revised August 2008. Accordingly this included examining on a test basis, evidence supporting the financial and statistical information included in the West Virginia Department of Health and Human Resources Financial & Statistical Reports for Nursing Homes and performing such other procedures as we considered necessary in the circumstances. We believe that our examinations provide a reasonable basis for our opinion.

Our examinations disclosed significant findings that are included in the attached Schedule Of Findings And Recommendations that, individually or in the aggregate, resulted in a material misstatement or deviation from the West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations established by the

West Virginia Department of Health and Human Resources. Additional specific significant findings may have been found if we had conducted a complete examination of the records.

In our opinion, except for the material misstatement/deviation described in the previous paragraph, the financial and statistical information included in the West Virginia Department of Health and Human Resources Financial & Statistical Reports for Nursing Homes of the Provider referred to above present fairly, in all material respects, the financial and statistical information of the Provider as of and for the six month periods ended June 30, 2004, December 31, 2004, June 30, 2005, December 31, 2005, June 30, 2006, December 31, 2006, June 30, 2007, and December 31, 2007 in accordance with the West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations established by the West Virginia Department of Health and Human Resources.

In accordance with *Government Auditing Standards*, we have also issued our report dated April 20, 2010 on our consideration of the Provider's internal control over financial reporting and on our tests of its compliance with the West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations established by the West Virginia Department of Health and Human Resources. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the internal control over financial reporting or on compliance. That report is an integral part of an examination performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our examinations.

This report is intended solely for the information and use of the West Virginia Department of Health and Human Resources, Office of Accountability and Management Reporting, and is not intended to be and should not be used by anyone other than this specified party.

Report On Internal Control Over Financial Reporting And On Compliance And Other Matters Based On An Examination Of The Financial & Statistical Reports Performed In Accordance With Government Auditing Standards

Department of Health and Human Resources
Office of Accountability and Management Reporting
One Davis Square
Suite 304
Charleston, West Virginia 25301

We have examined the West Virginia Department of Health and Human Resources Financial & Statistical Reports for Nursing Homes of as of and for the six month periods ended June 30, 2004, December 31, 2004, June 30, 2005, December 31, 2005, June 30, 2006, December 31, 2006, June 30, 2007, and December 31, 2007 and have issued our report thereon dated April 20, 2010 which was qualified because our examinations disclosed material findings that are included in the accompanying Schedule Of Findings And Recommendations that, individually or in the aggregate, resulted in a material misstatement or deviation from the West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations established by the West Virginia Department of Health and Human Resources. We conducted our examination in accordance with attestation standards established by the American Institute of Certified Public Accountants and the standards applicable to attestation standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

INTERNAL CONTROL OVER FINANCIAL REPORTING

In planning and performing our examinations, we considered Provider's internal control over financial reporting as a basis for designing our examination procedures for the purpose of expressing our opinion on the West Virginia Department of Health and Human Resources Financial & Statistical Reports, but not for the purpose of expressing an opinion on the effectiveness of Provider's internal control over financial reporting.

Accordingly, we do not express an opinion of the effectiveness on Provider's internal control over financial reporting.

Our consideration of internal control over financial reporting was for the limited purpose described in the preceding paragraph and would not necessarily identify all deficiencies in internal control over financial reporting that might be significant deficiencies or material weaknesses. However, as discussed below, we identified certain deficiencies in internal control over financial reporting that we consider to be significant deficiencies.

A control deficiency exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent or detect misstatements on a timely basis. A significant deficiency is a control deficiency, or combination of control deficiencies, that adversely affects the Provider's ability to initiate, authorize, record, process, or report financial data reliably in accordance with the accrual basis of accounting such that there is more than a remote likelihood that a material misstatement based on the Provider's internal control over financial reporting could occur. We consider the deficiencies in the accompanying Schedule Of Findings And Recommendations to be significant deficiencies in internal control over financial reporting.

Compliance And Other Matters

As part of obtaining reasonable assurance about whether the West Virginia Department of Health and Human Resources Financial & Statistical Reports for the Provider are free of material misstatement, we performed tests of its compliance with West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations established by the West Virginia Department of Health and Human Resources, noncompliance with which could have a direct and material effect on the determination of amounts and statistics reported in the West Virginia Department of Health and Human Resources Financial & Statistical Reports. However, providing an opinion on compliance with West Virginia Medicaid Provider Manuals and all other applicable laws, rules and regulations was not an objective of our examinations, and accordingly, we do not express such an opinion. The result of our tests disclosed instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards* and which are described in the accompanying Schedule Of Findings And Recommendations.

This report is intended solely for the information and use of the West Virginia Department of Health and Human Resources, Office of Accountability and Management Reporting, and is not intended to be and should not be used by anyone other than this specified party.

EXAMINATION OF WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES FINANCIAL & STATISTICAL REPORTS

PERIODS ENDED JUNE 30, 2004, DECEMBER 31, 2004, JUNE 30, 2005, DECEMBER 31, 2005, JUNE 30, 2006, DECEMBER 31, 2006, JUNE 30, 2007, AND DECEMBER 31, 2007

SCHEDULE OF FINDINGS AND RECOMMENDATIONS

Finding Number 2007-1 Bed Hold Days Claimed In Error

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.10 Bed Reservation: "A nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility. This is paid at the facility's established rate. The facility's occupancy must be 95% or greater the midnight before the resident leaves and there must be a waiting list for admission."

Condition: During our examination we noted that the provider billed and was paid for three bed hold days when their occupancy was below the 95% threshold.

Resident	Occupancy % day prior to transfer	Bed Hold Date(s)	Days on Bed Hold	Total Rate	Adjustment and Amount
LD	92.9%	4/1/06 - 4/2/06	2	$162.51	$325.02
AH	92.2%	4/2/06	1	$162.51	$162.51
			3	**TOTAL**	**$487.53**

Cause: The facility did not provide a cause.

Effect or Potential Effect: Bed hold days were overstated and the facility was overpaid by Medicaid.

Recommendation: We recommend that the facility put controls in place to ensure that bed hold days are not billed when they do not meet the criteria.

Finding Number 2007-2 Census Errors

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.28 Maintenance Of Records: "Financial and Statistical records must be maintained by the facility to support and verify the information submitted on the cost reports."

Condition: During our bed hold day testing, we noted 3 bed hold days the provider billed Medicaid in error during April 2006. These adjustments are included in the table below. During our examination we determined that the census days on Page/Line WV6/Total on the Financial & Statistical Reports listed below were over or under stated as follows:

Month Ended	Per Cost Report	Per Census		Difference
January 2005	2,935	2,934		(1) Overstated
March 2006	2,839	2,870		31 Understated
April 2006	2,881	2,847	*	(34) Overstated
January 2007	2,970	2,939		(31) Overstated

* Per Census includes adjustments from finding # 2007-1 Bed Hold Days Claimed In Error

Cost Report Period	FASR Cost Center	Page/ Line	Account Number and Title	Days Per FASR	Days Per Facility Records	Adjustment and Amount
6/30/2005	Census	WV6/ Total	N/A	17,005	17,004	Decrease Census by 1 day
6/30/2006	Census	WV6/ Total	N/A	16,701	16,698	Decrease Census by 3 days
6/30/2007	Census	WV6/ Total	N/A	16,939	16,908	Decrease Census by 31 days

Cause: The facility did not provide a cause.

Effect or Potential Effect: The census days are overstated on the June 30, 2005, June 30, 2006 and June 30, 2007 of the Financial & Statistical Report.

Recommendation: We recommend that the facility put controls in place to ensure that the Financial & Statistical Report is submitted accurately.

Finding Number 2007-3 Adjustments To Home Office Allocation

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.2.6 Provider Agreement: "Payment to the nursing facility for covered items and services it furnishes on or after the effective date of the agreement will require that the facility have a record keeping capability sufficient for determining the cost of services furnished to Medicaid recipients."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.23 Reimbursement Requirements: "The West Virginia LTC reimbursement system is prospective with semi-annual rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. To meet these goals, complete and accurate cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.24 Cost Finding and Reporting: "All participating facilities are required to maintain cost data and submit cost reports according to the methods and procedures specified in this chapter and the Medicaid Reimbursement Guide for Long Term Care Nursing Facilities which ever is more restrictive."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.28 Maintenance of Records: "Financial and Statistical records must be maintained by the facility to support and verify the information submitted on the cost reports....Upon request by the Department all records will be made available within ten (10) working days. If not produced within that time frame, the records will be considered non-existent.... Costs found to be unsubstantiated will be disallowed and considered as an overpayment."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.29 Allowable Costs: "Reimbursement for nursing facility service is limited to those costs required to deliver care to residents."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.30.6 Working Capital Interest: "Working Capital Interest (WCI) is limited to short term loans (normal term of less than six months) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and these notes are merely renewed throughout the year, the Program will not consider these to be bone fide working capital notes and the interest incurred on them will not be allowed if no justification can be made for nonpayment of the note"

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.30.9 Home Office Costs: "Home office costs are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain. Thus, allowable cost is limited to the lesser of (1) allowable costs properly allocated to the provider (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chain wide basis. Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. Costs related to nonmedical enterprises are not considered allowable home office costs. All allocated central office costs are considered administrative in nature and, therefore, must

comply with regulations governing allowability at individual facility locations. Starting with its total costs, including those costs paid on behalf of the providers (or components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.32 Non-Allowable Costs: "Non-allowable costs are those costs which are not related to patient care or for which a separate charge is made."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.32.4 Reorganization/Refinancing Costs: "Organization and reorganization costs are the costs incurred in the creation or restructuring of an entity. These costs are considered to be nonallowable for cost reporting and reimbursement purposes."

Criteria: Per the West Virginia Medicaid Provider Manuals Chapter 514.39.2 Field Audit: "Periodic on-site audits of the financial and statistical records of participating facilities will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report and all data to support payroll and census reports. Costs found to be unsubstantiated will be disallowed and considered as an overpayment."

Condition: During our examination of the cost reports for the six-month periods January 1, 2004 through December 31, 2007, we reviewed the Home Office Allocation to determine that the costs allocated to the Financial & Statistical Reports were allowable. Based on our review of these costs, we determined that some of the costs allocated to the Financial & Statistical Reports for the above six-month periods were non-allowable and therefore should not be included. The following is the total non-allowable cost by each six-month cost report period.

Six-Month Period Ended	Total
6/30/04	$ 15,106
12/31/04	20,924
6/30/05	28,626
12/31/05	11,297
6/30/06	156,170
12/31/06	134,672
6/30/07	29,500
12/31/07	32,846
Total Non-Allowable Costs	$429,141

Refer to the tables below that include the detail costs disallowed by the six-month cost period. The following by account titles are the types of costs that are disallowed and the reason(s) for the disallowance.

A. Legal Fees: During our review of the eight six-month cost report periods examined, we noted that management had included costs in an account titled legal fees which we

deemed to be non-allowable. The descriptions on the invoices that were deemed to be non-allowable were; liquor license, opposition to CON, restructuring,

LLC promissory note, research change in bed size, employee wrongful termination - settled, appeal of audit adjustments and other corporate matters. Reimbursement for nursing facility service is limited to those costs required to deliver care to residents. These legal fees by each six-month cost report period and the total non-allowable amounts are as follows:

Six-Month Period Ended	Amount
6/30/04	$ 15,106
12/31/04	20,924
6/30/05	28,626
12/31/05	11,297
6/30/06	31,114
12/31/06	2,040
6/30/07	29,500
12/31/07	32,846
Total Non-Allowable Costs	$171,453

B. Interest Expense: During our review of the eight six-month cost report periods examined, we noted that management had included costs in an account titled Adm - Interest Expense. We requested the loan documents to verify the terms, length, and purpose of the loan; after the review of the loan documents we noted that the loan documents stated that the loan's purpose was to refinance existing debt. Also, the loan documents referenced Exhibits A, B, C, D, and E which we requested from management and was not provided to us by management. The length of the loan was for twelve and a half months. During the exit conference the management stated that they needed to increase their line of credit from $2,000,000 to $3,000,000 and that is the reason the loan documents stated "Refinance existing debt" because they had to pay off the previous line of credit dated September 2, 2005. Using this reason would increase the length of the loan to fifteen and a half months, which we do not consider to be a short term loan. For the reasons stated above we have deemed the interest expense for this loan to be non-allowable. The interest expense by six-month cost report period and the total non-allowable amounts are as follows:

Six-Month Period Ended	Amount
6/30/06	$125,056
12/31/06	132,632
Total Non-Allowable Costs	$257,688

Refer to the following tables that include the accounts and costs disallowed by each six-month cost report period.

The reconciliations on the following pages by six-month cost report periods represent the original home office cost reported, less the non-allowable costs, and home office cost per

audit. The second part of the reconciliation represents the audited home office cost allocation to each facility.

Page 11 Has Been Redacted Due to Containing Sensitive Information

Page 12 Has Been Redacted Due to Containing Sensitive Information.

Page 13 Has Been Redacted Due to Containing Sensitive Information.

Page 14 Has Been Redacted Due to Containing Sensitive Information.

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Page 18 Has Been Redacted Due to Containing Sensitive Information.

Cost Report Period	FASR Cost Center	Page/ Line	Account Number and Title	Amount Reported per FASR	Correct Amount	Adjustment and Amount
6/30/2004	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$314,695	$313,040	Decrease $1,655
6/30/2004	Non-Allowable Expenses	WV24/ 23	9950 Other	$30,498	$32,153	Increase $1,655
12/31/2004	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$271,381	$269,042	Decrease $2,339
12/31/2004	Non-Allowable Expenses	WV24/ 23	9950 Other	$29,538	$31,877	Increase $2,339
6/30/2005	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$295,568	$292,345	Decrease $3,223
6/30/2005	Non-Allowable Expenses	WV24/ 23	9950 Other	$32,299	$35,522	Increase $3,223
12/31/2005	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$284,899	$283,678	Decrease $1,221
12/31/2005	Non-Allowable Expenses	WV24/ 23	9950 Other	$33,098	$34,319	Increase $1,221
6/30/2006	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$338,286	$320,334	Decrease $17,952
6/30/2006	Non-Allowable Expenses	WV24/ 23	9950 Other	$14,014	$31,966	Increase $17,952

12/31/2006	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$323,263	$307,790	Decrease $15,473
12/31/2006	Non-Allowable Expenses	WV24/ 23	9950 Other	$25,908	$41,381	Increase $15,473
6/30/2007	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$335,162	$331,848	Decrease $3,314
6/30/2007	Non-Allowable Expenses	WV24/ 23	9950 Other	$13,510	$16,824	Increase $3,314
12/31/2007	Administration	WV20/ 46	N/A Central Office Allocation From WV20	$295,953	$292,243	Decrease $3,710
12/31/2007	Non-Allowable Expenses	WV24/ 23	9950 Other	$26,664	$30,374	Increase $3,710

Cause: The facility did not provide a cause.

Effect or Potential Effect: Allowable expenses on the Financial & Statistical Report are overstated.

Recommendation: We recommend that the facility put controls in place which will ensure home office expenses that are non-allowable are classified in the proper non-allowable account and not allocated to the cost report

HHR13017 ADDENDUM ATTACHMENT B2

Supplemental Response "A"

HHR12070 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

WEST VIRGINIA DHHR OAMR

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

YEAR 1 ALL-INCLUSIVE COST SHEET

FACILITY	General Location
1. Eagle Pointe	Home Office (Indianapolis, IN)
2.Weirton Medical Center	Hospital Based SNF
3.Guardian Elder Care at Wheeling	Hospital Based SNF
4.Arbors at Fairmont	Home Office (Milwaukee, WS)
5.Broaddus Hospital-Mansfield Place	Hospital Based SNF
6.Greenbrier Manor	
7.Pleasant Valley Nursing and Rehabilitation Center	Hospital Based SNF
8.Good Samaritan Society- Barbour County	Home Office (Sioux Falls, SD)
9.Montgomery General Elderly Care Center	
10.Grant Memorial Hospital	Hospital Based SNF
11.Montgomery General Hospital Extended Care	Hospital Based SNF
12.Morgan County War Memorial Hospital	Hospital Based SNF
13.Minnie Hamilton Health Care Center, Inc.	Hospital Based SNF
14.Roane General Hospital	Hospital Based SNF
15.St. Josephs Hospital of Buckhannon, Inc.	Hospital Based SNF
16.Summers County ARH	Hospital Based SNF
17.Summersville Memorial Hospital	Hospital Based SNF
SUBTOTAL FOR STANDARD ENGAGEMENTS COST Year 1	

HHR13017 ADDENDUM ATTACHMENT B2

Supplemental Response "A"-continued

HHR 12070 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

WEST VIRGINIA DHHR OAMR

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

YEAR 2 ALL-INCLUSIVE COST SHEET

FACILITY	**General Location**
1. Heartland of Charleston	Chain – Home Office (Toledo, OH)
2. Heartland of Beckley WV, LLC	
3. Heartland of Keyser	
4. Heartland of Clarksburg	
5. Heartland of Martinsburg	
6. Heartland of Preston County	
7. Heartland of Rainelle WV, LLC	
8. SunBridge Care & Rehabilitation For Dunbar	Chain – Home Office (Albuquerque, NM)
9. SunBridge Care & Rehabilitation For Salem	
10. SunBridge Care & Rehabilitation for Pine Lodge	
11. SunBridge Care & Rehabilitation for Putnam	
12. Sunbridge New Martinsville Health Care Center	
13. SunBridge Care & Rehabilitation for Parkersburg	
14. SunBridge Care & Rehabilitation for Glenville	
15. Holbrook Nursing Home	
16. Nella's Inc.	
17. Nellas Nursing Home, Inc.	
SUBTOTAL FOR STANDARD ENGAGEMENTS COSTS Year 2	

Supplemental Response "A"-continued

HHR 12070 Auditing of Long Term Care Financial and Statistical Reports (LTC-FASR)

WEST VIRGINIA DHHR OAMR

COST QUOTE FOR STANDARD FACILITY ENGAGEMENT

YEAR 3 ALL-INCLUSIVE COST SHEET

FACILITY	General Location
1. Huntington Health & Rehabilitation	Home Office (Houston, TX)
2. Golden LivingCenter-Glasgow	Chain – Home Office (Ft. Smith, AR)
3. Golden LivingCenter-Morgantown	
4. Golden LivingCenter-Riverside	
5. Hampshire Memorial Hospital	Hospital Based SNF
6. The Maples	
7. Clarksburg Nursing & Rehabilitation Center	Chain – Home Office (Charleston, WV)
8. McDowell Nursing & Rehabilitation Center	
9. Summers Nursing & Rehabilitation Center	
10. Fayette Nursing & Rehabilitation Center	
11. E.A. Hawse Nursing & Rehabilitation Center	
12. Lincoln Nursing & Rehabilitation Center	
13. Cameron Nursing & Rehabilitation Center	
14. Wayne Nursing & Rehabilitation Center	
15. Webster Nursing & Rehabilitation Center	
16. Wyoming Nursing & Rehabilitation Center	
17. Mercer Nursing & Rehabilitation Center	
Subtotal FOR STANDARD ENGAGEMENTS COSTS Year 3	

4.19 Payments for Medical and Remedial Care and Services

Methods and Standards for Determining Payment Rates for non-State-Owned Nursing Facilities - Excludes State-Owned Facilities

I. Cost Finding and Reporting

All nursing facilities certified to participate in the program are required to maintain cost data and submit cost reports according to the methods and procedures prescribed by the State agency.

A. Chart of Accounts

The Department adopted the Chart of Accounts for Long Term Care Facilities published by the American Nursing Home Association as the basic document for the LTC system July 1, 1975. The basic chart of accounts is updated and modified periodically and has been converted to a mandated computerized format. This standard computerized cost reporting mechanism must be used by all participating facilities to maintain facility cost data for cost reporting and auditing purposes.

B. Financial and Statistical Report

Facility costs for nursing facilities must be reported on the computerized format of the Financial and Statistical Report for Nursing Homes. These reports must be completed in accordance with generally accepted accounting principles using the accrual method of accounting and must be complete and accurate. Facilities are also required to submit a trial balance of the reporting entity as of the closing date of the reporting period. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

C. Cost Reporting Periods

All participating facility costs are reported semi-annually. The six-month reporting periods are January 1st through June 30th, and July 1st through December 31st.

D. Filing Periods

Cost reports must be filed with the State agency and postmarked within sixty (60) days following the end of the reporting period. The due dates are March 1st for the December 31st closing date and August 29th for the June 30th closing date.

4.19 Payments for Medical and Remedial Care and Services

Methods and Standards for Determining Payment Rates for Non-State-Owned Nursing Facilities- (Excludes State-Owned Facilities)

An extension of time for filing cost reports may be granted by the State agency for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Requests for an extension of the filing period are to be addressed in writing to the Director, Financial Analysis and Rate Setting, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, West Virginia 25301-3706.

E. Penalty - Delinquent Reporting

Failure to submit cost reports within the mandated (sixty [60] days) filing period, where no extension has been granted to the facility or within the time constraints of an extension, will result in a ten percent (10%) reduction in reimbursement to that facility. The penalty will be assessed on payments for services delivered on the day(s) the report is late.

Incomplete cost reports returned to the facility for correction which are not promptly completed and resubmitted within specified time constraints, may be subject to the following penalty provision: Facilities submitting cost reports after the beginning of the rate period; i.e., April 1st or October 1st, will receive rate adjustment effective the month following the month the cost report was received.

F. Correction of Errors

Errors in cost report data identified by the facility may be corrected if resubmitted with thirty (30) days after original rate notification. Only those corrections received by the Department within the thirty (30) day period will be considered for rate revision. The Department will make rate revisions resultant from computational errors in the rate determination process.

4.19 Payments for Medical and Remedial Care and Services

ATTACHMENT 4.19-D-1

Methods and Standards for Determining Payment Rates for Non-State-Owned Nursing Facilities - (Excludes State-Owned Facilities)

G New Facilities - Projected Rates

A projected rate will be established for new facilities with no previous operating experience A change of location with the same ownership does not constitute a new facility Each such facility on a projected rate must submit the calendar semi-annual cost reports during the projected rate period beginning with the first full six months operating experience in a reporting period

H Change of Ownership - Projected Rates

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility

Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by the State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting projected rates.

Each such facility on a projected rate must submit the required semi-annual cost reports during the projected rate period beginning with the first 3 months operating experience in a reporting period.

I Maintenance of Records

Financial and statistical records must be maintained by the facility to support and verify the information submitted on cost reports Such records must be maintained for a minimum of five (5) years from the date of the report, and will be furnished upon request to the Department or Federal officials

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The State agency will maintain cost reports for a minimum of seven (7) years from date of receipt.

II. Allowable Costs

Reimbursement for nursing facility services is limited to those costs required to deliver care to patients. These are facility operating costs, patient direct service costs, and costs for the physical setting.

Allowable Costs for Cost Centers

Cost center areas are standard services, mandated services, nursing services, and capital. A cost upper limit is developed for each cost center area and becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

1. Standard Services

Standard services are Dietary, Laundry/Housekeeping, Medical Records, and Administration. Cost standards for these services are computed from the current cost report; i e., salaries, supplies and services as submitted by the facilities. Total allowable costs for all patients are arrayed assuming 100% occupancy; i.e., licensed beds times days, to establish a per patient day cost. The costs are then arrayed by bed range; i.e., 0-90 and 91 plus Extremes are eliminated by including only those values falling within plus or minus one standard deviation This establishes a cost average point (CAP), i e , average cost per bed range. The CAP is then adjusted by a 90% occupancy level to establish the cost standard for each standard service department. These standard service departments' cost standards are then summed to obtain a cost ceiling that establishes the maximum allowable cost by bed range for the standard services

2. Mandated Services

Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the percentile of allowable reported costs

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by facility classification as determined from the current cost report.

3. Nursing Services

Allowable costs and reimbursement for nursing services will be determined by the kind and amount of services needed by and being delivered to the residents, the staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility. Such determination will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by case mix characteristics.

Monthly billing forms for services rendered to nursing home residents will include data directly derived from the computerized MDS for each resident, which will be used to determine composite case mix scores for each resident and for the facility. These case mix scores will measure the relative intensity of service needs of the facility residents and will comprise the basis for determining allowable adjustments to per diem staffing and costs required to deliver the kind and amount of services needed.

4. Cost of Capital

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). The value includes the necessary real property and equipment associated with the actual use of the property as a long term care facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Home Standard, where appropriate. This valuation is the basis for capitalization to determine a per patient day cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest, and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting them from the estimated accrued depreciation, and adding the market value of the land (actually used or required for use as if vacant and available for

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development of such use). Established sources of cost information are used to supply costs to reproduce the structure Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

b Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the "breakdown" method which involves an analysis of loss in value from the following sources:

(1) Physical deterioration; curable and incurable.
(2) Functional obsolescence; curable and incurable.
(3) Economic obsolescence.

The modified appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Facility Standard

The Model Facility Standard is a composite of current regulations and criteria derived from several sources which include "Minimum Requirements of Construction and Equipment for Hospital and Medical Facilities"--HHS Publication No. (HRS) 81-14500, and West Virginia Rules and Regulations, where appropriate. These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice They will be updated periodically to reflect changes which foster improved patient

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care or cost effective measures which do not compromise patient care

d Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually prior to the October rate setting period. Updates may be performed at anytime during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate purposes. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index.

A copy of the facility appraisal report is furnished to the facility for its records.

5 Compensation

Compensation to be allowed must be reasonable for services that are necessary, related to patient care and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked and compensation must be documented and reported to all appropriate State and Federal authorities for income tax, Social Security, and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the bed ranges If the services are provided less than full time, the compensation must reflect this fact Full time is considered approximately 2,080 hours per year worked in patient-related duties.

Compensation must include the total benefit paid for the services rendered; i e., fees, salaries, wages, payroll taxes, fringe benefits, and other increments paid to or for the benefit of those providing the services.

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6 Administrators

Compensation for administrators who do not work full time will be proportionate to the total number of hours worked. This includes persons who hold administrative positions in more than one facility, as well as those who hold various other positions in the same or alternate facility

7 Owners

Administrators/owners will be compensated for administrative duties performed. Where the costs of administrative services are allowed, additional services performed by the administrator and/or owner are considered rendered primarily to protect their investment and are not allowable.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative functions required to operate the facility where the facility has a full-time administrator and/or assistant administrator or where other full-time or part-time staff positions are filled. Owner includes any individual or organization with an equity interest in the facility operation and any member of such individual's family including spouse's family Owner also includes all partners and all stockholders in the facility operation and partners and stockholders of organizations which have an equity interest in the facility

8. Nonallowable Costs

Bad debt, charity, and courtesy allowances are not included as allowable costs. Other items of expense may be specified in the State agency regulations as nonallowable costs.

9 Purchase from Related Companies or Organizations

All related companies or organizations involved in any business transactions with the facility must be identified on the cost report Detailed data must be available in the facility records which describe the nature and extent of such business transactions.

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Cost for purchases of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

III. Rate Determination

Individual facility rates are established on a prospective basis, based on licensed beds, considering cost to be expected and allowable during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors or omissions of data, reconciliation of audit findings related to falsification or misreporting costs, or incorrect reporting of census or costs. The basic vehicle for arriving at each facility's rate is the uniform Financial and Statistical Report.

The reported costs are subject to desk audit and then converted to rates per patient day. Rates will be in effect for six-month (6) periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period.

Effective October 1, 2005, the Bureau will freeze a long term care nursing facility's rate with a maximum reduction of $1 00 per patient day. The freeze will last for two rate periods and end September 30, 2006. All other long term care nursing facility regulations, policies and procedures will remain in effect throughout the freeze period unless otherwise modified through general updating practices.

A. Cost Adjustment

Reported facility costs are subject to review and analysis through desk audit Adjustments are made to exclude nonallowable costs and by application of the agency's established cost standards using the following methodologies:

1. Standard Services

Reported allowable costs in the standard services area are compared against the cost ceiling for standard services using the appropriate bed range for the facility or facility class. If the allowable reported cost exceeds the cost ceiling, then the facility rate is limited to the ceiling.

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2. Mandated Services

Mandated services are defined as Maintenance, Utilities, Taxes and Insurance, and Activities. Reported allowable cost for these services is fully recognized to the extent that it does not exceed the 90th percentile of allowable reported costs by facility classification as determined from the current cost report.

3. Cost of Capital

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraised Value (SAV) methodology.

a. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, and an allowance for return on equity investment in the land, building and equipment.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate which may be changed semi-annually to reflect current money values in the mortgage market. This band of investment sets a 75:25 debt-service to equity ratio.

The yield on equity allowance is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The interest rate for the mortgage component will be based upon an average of the Prime Rate of interest as published by the Federal Reserve Board. A ten (10) year running average of the Prime Rates will be calculated by the Bureau, with an additional three (3) percentage point added to the calculated interest rate average in order to establish, as needed, the allowable interest rate to be used for rate setting purposes. A floor and ceiling with a maximum of twelve (12) percent and a minimum of ten (10) percent, respectively, will be used in the interest rate calculation.

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b. Capital Allowance

All facilities per patient day capital allowance shall be determined by applying the capitalization rate for the mortgage and equity component to the valuation of the facility determined by the Standard Appraised Value methodology As facility valuations under SAV methodology are updated annually over a period of several months, all derived facility valuations will be standardized to June 30 of each year using the Consumer Price Index.

The proposed change in capital cost will be phased in over four (4) rate setting periods as follows:

October 1, 2006, 25%
April 1, 2007, 50%
October 1, 2007, 75%
April 1, 2008, 100%

4. Nursing Service and Restorative Servies

Nursing and related service costs, including restorative services, will be determined on a facility-by-facility basis by applying the allowable cost formula and case mix adjustments Nursing service reimbursement will consist of an adjusted base component and allowable case mix add-on.

The base nursing services component will reflect minimum staffing patterns for nursing personnel, plus a factor to account for restorative services, and amounts reflecting Director of Nursing costs and the costs of supplies and services. Basic nursing staffing is established at a case mix score of 2.5, which reflects nursing and restorative staffing hours per patient day as follows:

# of Beds	Position	Nursing	Restorative	Total
1-90	R.N.	.20	.00	20
	L.P.N	.50	35	.85
	Aides	1.80	.05	1.85
TOTAL		2.50	40	2 90
91+	R.N.	.20	00	20
	L.P.N	.50	30	80
	Aides	1.80	.05	1.85
TOTAL		2.50	35	2 85

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Multiplying these PPD staffing patterns by the 70th percentile value of hourly wages, based on total compensation for the peer group yields the nursing services CAP, or ceiling, for each facility in the peer group.

A factor is added for supplies equal to the PPD supply costs at the 70th percentile for the bed groups determined from the submitted cost reports. An additional factor is added for the Director of Nursing (DON) by dividing the DON salary at the 70th percentile from the bed range, as derived from the submitted cost reports, by each facility's beds at 100% occupancy. Adding these factors together yields the base constant through the six-month reimbursement period.

The peer group CAP is then adjusted to a facility specific CAP based on that facility's average MDS score from the six month reporting period. The average MDS is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted nursing CAP for each facility. The adjusted nursing CAP cannot exceed 112% (MDS average of 2.8), or be less than 80% (MDS average of 2.0), of the base constant.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the reimbursement period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a resident in a given facility. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD nursing services add-on.

5. Minimum Occupancy Standard

Cost adjustments will be made by applying a minimum occupancy standard of 90% of all cost centers. Actual facility occupancy is used to determine allowable cost per patient day if equal to or greater than 90%. When the actual occupancy level is less than 90%, the actual allowable per patient day cost will be adjusted to assume a 90% occupancy level.

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B. Efficiency Incentive

An efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost ceilings. Fifty percent (50%) of the difference between the allowable costs and the cost ceiling will be applied to the prospective rate for the standard services area. The total of the calculated efficiency incentive may not exceed $2.00 per patient day.

Quality Assurance

A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care as defined by the surveying agency during the reporting period. Survey and licensure agency reports are reviewed to determine compliance with licensure, certification and agency standards. If it has been determined that a facility has significant deficiencies, the facility will be denied efficiency incentive for that period.

C. Inflation Factor

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. In setting an inflation factor, changes in industry wage rates and supply costs compared with CPI are observed and the lesser amount of change is expressed as a percentage and applied to the allowable reimbursable costs for the six-month rate setting period. The amount of change experienced during the six-month reporting period or the CPI becomes the inflation factor applied to the next six-month rate setting period. The inflation factor, once set for a given rate period, is not adjusted as it represents a reasonable expectation for cost increases.

Indicators used for tracking economic changes and trends include:

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I. Semi-Annual Cost Reporting - The average per patient day cost of service is compared to the cost incurred in providing the same services in the prior cost reporting period. The percentage of change is then expressed as an increase or decrease in the cost from the prior period.

II. Regulatory Costs - Regulatory costs, such as minimum wage increase, FICA increase, and Worker's Compensation changes may be considered as a component of the inflation factor.

III. National Data - The Consumer Price Index (CPI) for the most current cost reporting period is analyzed and compared with state experience.

D. Change in Bed Size

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if it affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the change in bed size has been certified.. Any revision of the per diem rate as a result of the change in bed size will become effective with the month the facility changes were certified by the state survey agency.

E. Projected Rates

Projected rates will be established for new facilities with no previous operating experience for a period of eighteen (18) months. The facility may choose to go off the projected rate at any time after a full six (6) months of operating experience in a cost reporting period. Projected rates may be established for a maximum period of eighteen (18) months where there has been a change of ownership and control of the operating entity, and the new owners have no management experience in the facility. Where there has been a change of ownership from a corporation to an individual or individuals, from an individual or individuals to a corporation, or from one corporation to another, the ownership of the stock of the corporation(s) involved will be examined by State agency in order to determine whether there has been an actual change in the control of the facility. Where ownership changes from an individual to a partnership, and one of the partners was the former sole owner, there has been no change of control.

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Where the immediate former administrator and/or persons responsible for the management of a facility purchases that facility, there has been no change of control for the purpose of setting a projected rate.

At the end of the projected rate period, actual cost experience of the facility will be reconciled with the projected cost reimbursement and tested for reasonableness against the standards established for the bed range for the appropriate rate periods.

For facilities constructed after April 1, 1981 and financed by public bonded indebtedness, the actual cost experience of the facility will be based on the actual occupancy experience of the facility during the projected rate period, rather than the minimum occupancy standard However, these actual costs will be compared with the same standards, as detailed above, and therefore subject to the same test of reasonableness.

Resulting overpayments from overprojection will be recovered by the State agency in accordance with provisions of Chapter 700, Long Term Care Regulations.

Rates based on projected costs do not include management incentives or occupancy allowance.

1. New Facilities

A projected rate for new facilities with no previous operating experience will be established as follows:

a. Standard Services - The cost standard established for the appropriate bed range peer group

b. Mandated Services - The established CAP for the appropriate bed range peer group

c. Nursing Services - The average of the costs established for the appropriate bed range peer group

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d Cost of Capital - The Standard Appraised Value (SAV) methodology applied to the facility The facility will be appraised following certification for participation in the program.

2 Change of Ownership

A projected rate established for facilities where there has been a recognized change of ownership and control will be established as follows:

a Standard Services - The cost standard established for the appropriate bed range peer group.

b Mandated Services - The CAP of the costs established for the appropriate bed range peer group.

c. Nursing Services - The average of the cost established for the appropriate bed range peer group.

d Cost of Capital - The Standard Appraised Value (SAV) established for the facility.

IV Administrative Review

Procedures to be followed for administrative review and evidentiary hearings related to the per diem rate established for facility reimbursement are found in Chapter 700, Long Term Care Regulations

V Audits

Department audit staff will perform a desk audit of cost statements prior to rate setting, and will conduct on-site audits of facility records periodically

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A. Desk Audit

Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within sixty (60) days of receipt. Incomplete and inaccurate cost reports are not accepted.

B. Field Audit

Periodic on-site audits of the financial and statistical record of each participating facility will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report, and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff for audit purposes upon notice. Records found to be incomplete or missing at the time of the scheduled on-site review, must be delivered to the Department within forty-eight (48) hours or an amount of time agreed upon by audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.

C. Record Retention

Audit reports will be maintained by the agency for five (5) years following date of completion.

D. Credits and Adjustments

The State will account for and return the Federal Portion of all overpayments to CMS in accordance with the applicable Federal laws and regulations.

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VI. Bed Reservation Policy

Reimbursement will be made to reserve a bed during a resident's temporary absence from the facility at the established per diem rate provided the facility is fully (95% or greater) occupied and has a waiting list for admissions. A day of absence is defined as a twenty-four (24) hour period.

Medical Leave of Absence

A bed may be reserved for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, and whose stay is more than twenty-four (24) hours.

The maximum number of days of medical leave for a resident is twelve (12) days in a calendar year.

Therapeutic Leave of Absence

A bed may be reserved for a therapeutic leave which is included in the resident's plan of care.

The maximum number of days of therapeutic leave for a resident is six (6) days in a calendar year.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: HHR13017

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:
(Check the box next to each addendum received)

[ ] Addendum No. 1
[ ] Addendum No. 2
[ ] Addendum No. 3
[ ] Addendum No. 4
[ ] Addendum No. 5
[ ] Addendum No. 6
[ ] Addendum No. 7
[ ] Addendum No. 8
[ ] Addendum No. 9
[ ] Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

____
Company

____
Authorized Signature

____
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.