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STATE OF WEST VIRGINIA
DEPARTMENTS OF HEALTH, HEALTH FACILITIES, AND HUMAN SERVICES

Office of Shared Administration
Office of Accountability and Management Reporting

DATE: February 13, 2026

TO: Medicaid Certified Nursing Facilities
(Please give a copy of this memo to your cost report preparer)

FROM: Barbara Skeen, Director, Div of Rate Setting and Provider Reimbursement
Office of Accountability & Management Reporting

RE: Financial and Statistical Reports ended December 31, 2025

The December 31, 2025 cost report is **DUE no later than Tuesday, March 31, 2026**. The cost report and all supporting documentation must be submitted electronically using the Office of Accountability and Management Reporting's (OAMR) secure file transfer portal (SFTP). If the person responsible for submitting your facility's cost report has changed since last year, you will need to contact our office to provide the updated information so the new person can obtain a login for the SFTP.

As a reminder, cost reports are now completed on an annual basis. The 12/31/25 cost report will contain data from January 1, 2025 – December 31, 2025. The cost report software has been developed by Baker Tilly. If you have not yet contracted with Baker Tilly to utilize the cost report software or have questions or issues using the cost report software, please contact:

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Director - Baker Tilly Digital
Baker Tilly Advisory Group, LP
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AREAS HIGHLIGHTED or BOLDED ARE NEW REPORTING REQUIREMENTS OR REMINDERS

Recent desk reviews and rate setting cycles have identified a few recurring problems regarding cost report information submitted to OAMR for rate determination. As a result, the following are requirements that **MUST** be adhered to by each nursing facility seeking a rate for Medicaid participation:

- On **WV1, WV2, and WV3,** the following information **MUST** be correct: facility name,

address, phone number, cost report preparer, ownership information, and administrator name and email address. **The administrator's email is mandatory as it will be used to email the rate letter. If you do not include the correct email address for the administrator on WV3, you will not receive your rate letter. If the administrator changes after the cost report is submitted, the updated information must be provided to our office.**

- The Medicaid Cost Report, Medicaid Grouping Report, Facility Trial Balance, Trial Balance by Medicaid Chart of Accounts, Schedule of Adjusting Entries and attachments **MUST** be uploaded **individually** to the SFTP at the same time the cost report is uploaded.

- **Please make sure all insurance is properly categorized on WV19 (Property Insurance, Malpractice Insurance, Other Insurance and Liability Insurance). According to Chapter 514.12.25, Damage Awards and Negotiated Settlements:** Liability damages paid by the provider, either imposed by law or assumed by contract, which should reasonably have been covered by liability insurance, are not allowable. Any settlement negotiated by the provider or award resulting from a court or jury decision of damages paid by the provider in excess of the limits of the provider's policy, as well as the associated legal deductibles or legal costs is non-allowable.

- Total assets on WV6 **MUST** equal total equity/liabilities on WV7. The cost report will be deemed incomplete and returned if it is not in balance. A rounding difference of less than $10.00 will be considered acceptable.

- WV11 has a new line (line 18) this year for Resident Specific Equipment. Resident specific equipment including Class A Beds – Clinitron, Class B Beds – Low Air Fluidized, Wound Vacuum, Bariatric Beds, Bariatric Lifts, BiPAP, CPAP, Nebulizer and Concentrator. These resident specific items are to be reported on WV11/18.

- **ALL** "Other" accounts (including Central Office) **MUST** be described in detail on a separate accompanying schedule unless the account description on the Medicaid Grouping Report is sufficient to identify the contents of the account ("Purchased Services" **IS NOT SUFFICIENT**). **ALL DOCUMENTATION MUST BE SUBMITTED AT THE TIME THE COST REPORT IS FILED IN ORDER TO BE "FILED TIMELY."**

- ALL "Purchased Services" **AND** "Consulting Services" accounts listed on the cost report and grouping report **MUST** be described **in detail** on a separate accompanying schedule. **PLEASE INCLUDE VENDOR NAME, AMOUNT AND PURPOSE OF SERVICE. Credit card payments, petty cash reimbursements, etc. MUST be detailed for every purchase (no summaries). Just listing a person or business that was paid is NOT SUFFICIENT**. Be sure the description provided for the purpose of the service is complete and thorough on the schedule provided. If we cannot determine the purpose of the service, it will not be allowed.

- **ALL** items posted to Medicaid account #8790 Public Relations **MUST** be described **in detail** on a separate accompanying schedule. Allowable are promotional expenses such as brochures, pens, mugs and resident funeral flowers but **NOT** TV, radio, newspaper advertising (#8632); family/resident activities (#7420), employee flowers (#9950). It must be documented that the nursing facility received some type of public recognition (i.e. name in program, on signs, radio announcement) in order for payment to groups and charities to be allowable or it will be considered a donation and moved to non-allowable (#9950). We have previously found some public relations expenses in Want Ads and Other Advertising. Please put these expenses in Public Relations and include a detailed

schedule. Be sure the description detail provided is thorough, and the complete description is visible on the schedule provided. If we cannot determine from the description provided that the item is allowable, it will be moved to non-allowable.

- Restating the description from the Grouping Report as the detail on the supporting schedules is NOT acceptable. The total for the details must also equal the total in the grouping report. Any cost reports that have schedules that do not have proper descriptions or traceable totals will be considered incomplete and expenses will be moved to non-allowable.

- For hospitals, it is acceptable that your detail ties to the per books total. However, it is necessary that the allocation % used is documented. If items have been reclassified before the allocation, please label each reclassified item with the account it was moved to.

- Bed reservations (bed holds) are reported on the Census Report on WV4. Please be aware that there was a significant change to the bed hold policy that went into effect on October 1, 2024. See Chapter 514.8.3. Facilities are now permitted 18 bed holds (for all types of leave) per resident per calendar year. The 95% occupancy requirement has been eliminated. Revenue Code 0185 is to be used for a covered bed hold leave of absence and Revenue Code 0189 is to be used for a non-covered leave of absence. Please make sure your billing staff is aware of these changes.

  Please submit a schedule with the following information (a blank schedule is attached for your use):

  1. Reported bed holds by payer type (Medicaid or Other)
  2. Indicate if the Medicaid bed hold was billed & payment received. Only paid bed holds should be included on WV4
  3. Resident last name and initial with discharge and re-admit dates for only Medicaid bed holds. Resident identifiers are no longer needed.

- Nursing facility administrator salaries are reviewed for reasonableness. Please refer to Section 514.12.20 of the Medicaid Provider Manual for the calculation. For the cost report period January 1, 2025 – December 31, 2025, the administrator salary CAP is **$104.40/hr** for the small bed group and **$98.52/hr** for the large bed group. The facility is allowed the lesser of their actual expense (total compensation of the administrator) or the CAP.

- Mileage no longer needs to be reported on a separate schedule. The allowable portion of vehicle expense includes mileage paid to employees, gasoline, lease expense, depreciation and interest, auto insurance, registration and personal property tax and will be mapped to acct #8750 on line 17 (Vehicle) on WV16. The non-allowable portion of vehicle expense will be mapped to acct #9810 on line 7 (Nonallowable Vehicle) on WV22.

- To ensure that all expenses are mapped properly, please put employee background checks on WV 20/12 – Employee Benefits – Other (#9070), copier rental and maintenance on WV 16/6 – Equipment Rental (#8660), shredding service on WV 16/22 - Other (#8820) and hazardous waste disposal on WV 19/6 - Garbage (#9250).

- A portion of AHCA and WVHCA dues for lobbying is non-allowable and should be mapped to WV 22/20 - Other. Medicaid account #9950 should be used with “Non-Allowable Dues” as the account description. The non-allowable portions for 2025 are 30% AHCA and 16.5% WVHCA.

- Effective July 1, 2026, the capital component of the rate for each facility shall be based on a fair rental value (FRV) reimbursement system. A memo was sent to all facilities in October providing more detail about the FRV rate methodology. You can find the information about the FRV methodology on the Bureau for Medical Services website.

- According to Medicaid Regulation 514.9 Ancillary Services, the nursing facility must have formal arrangements for the provision of ancillary services which are necessary to support the primary activities of the nursing facility; however, they are not included in the per-diem rate.
    - Prescription Drugs
    - Prosthetics and Orthotics
    - Dental Services
    - Vision Care Services
    - Podiatry Services
    - Laboratory, X-Ray, and Other Diagnostic Services
    - Ambulance Services

  Because these services are billed directly to the Bureau, they are **NOT** included in the per diem rate and, therefore, should **ONLY** appear on WV22 of the cost report. Any of the above expenses found on the cost report during desk review without written description and supporting documentation submitted to justify the departure from Medicaid Regulation 514.10 will be moved to non-allowable.

All cost reports are to be uploaded to the SFTP located at: https://eft.wvdhhr.org.

Any cost report which does not comply with the Department of Human Services regulations will be considered unacceptable and subject to the penalty for delinquent reporting of costs in accordance with the state plan.

As a result of the due date for the submission of the December 31, 2025 cost report being extended until March 31, 2026, extensions will not be granted. Since rates don't go in effect until July 1, 2026, it may look like we have extra time to complete the desk reviews and should be able to grant extensions, However, since the rates are now calculated by Myers & Stauffer, we have less time than before to complete our desk reviews and make any needed adjustments. We must complete all the desk reviews, make the needed adjustments, compile all of the data, and get the data to Myers & Stauffer quickly so they can then begin calculating the rates. Therefore, all cost reports must be uploaded to the SFTP no later than the end of the day on March 31, 2026.

For any questions concerning the cost report, please contact Barbara Skeen, Director of Rate Setting and Provider Reimbursement, Office of Accountability and Management Reporting at barbara.i.skeen@wv.gov and also copy David McCauley at David.McCauley@wv.gov. Barbara Skeen 304 352-6728, David McCauley 304 352-6736

Medicaid Bedholds
1/1/25 through 12/31/25

Resident Last Name, First Initial	Discharge Date	Re-Admit Date	Days Billed	Days Paid

Schedule of Bedholds by Payer

Medicaid Cost Report

For the Period Ending 12/31/2025

	January	February	March	April	May	June	July	August	September	October	November	December	Total
Medicaid													
Other													
Total													