APPENDIX A -- MISSOURI RESIDENTIAL COST REPORT AND INSTRUCTIONS

The Missouri Residential Cost Report and instructions are available in a self extracting electronic file for all affected agencies. The file will be provided via electronic mail or on disk and include instructions for installation and contact information for questions regarding the cost report submission.

AGENCY INFORMATION

The data entered on the Agency Information screen is very important because it will be used to establish file names, print ranges, and the size of data export files. If the information on this screen is incomplete or incorrect, the Department may not receive all of the data entered into the MO_RATES model, and also may not be able to associate it with your agency if the FEIN number is not entered correctly. Also, please make sure to enter the correct Begin and End Dates for the report being submitted, especially if it is a quarterly report.

The FEIN number should be formatted as 99-9999999.

The begin and end dates should be formatted as mm-dd-yyyy. The dashes between the month, day and year are important for the date to be properly formatted. Also, note that the year is formatted for 4 digits (2004). The number of programs reported on the MO_RATES simply identifies how many separate programs (excluding the agency as a whole and 'Other not allocated') will be contained in the report. This is important so the spreadsheet will know how many columns to print out.

In the Actual Costs cell, enter an "A" for actual costs are reported. Enter a "B" if budgeted costs are reported.

In the Quarters Reported cell, enter a 4 for a full year of costs is reported.

In the Type of Ownership cells, place an "X" in the appropriate cell to identify the type of ownership. An "X" should be placed in only one cell.
In the Basis of Maintaining Acctg Records cells, place an "X" in the appropriate cell to identify the basis of maintaining the agency's records. An "X" should be placed in only one cell.

In the Agency Accreditation Completed By cell, enter the name of the body, which has accredited your agency if such an accreditation has occurred.

PROGRAM NAMES

The program names for purposes of the Missouri DSS residential rate analysis have been pre-entered for the first six programs. Programs seven through ten are available for additional reporting.

COSTS

Listed below is a definition for each line of the cost report, along with examples in most cases.

PLEASE NOTE THAT THE TOTAL COSTS ARE REPORTED ON LINES 1 THROUGH 44. THIS INCLUDES NON-REIMBURSABLE EXPENSES. THE NON-REIMBURSABLE EXPENSES ARE AGAIN REPORTED ON LINES 45 THROUGH 48 WHERE THEY ARE DEDUCTED FROM THE TOTAL EXPENSES TO RESULT IN THE NET EXPENSES CALCULATED ON LINE 49.

SECTION 1. DIRECT PROGRAM EXPENSE DEFINITIONS

Direct program expense is that which is caused directly by the personnel and object expenses in a program. It does not include management and general (general and administrative) or other administrative expenses. Similarly, support and ownership costs are reported elsewhere.

Line 1. Program Staff Salaries

Report the accrued salaries of program staff here. Do NOT report contracted staff or consultants on this line.

Examples would include licensed clinical social workers, registered and licensed nurses, child care workers, counselors, and paraprofessional aids. Report on-staff psychologists and physicians here. Teachers should also be reported here.

Contracted program staff, including contracted temporaries should be reported on line 4.

Report the cost of program clerical staff on line 2.

The total salaries reported on the PERSONNEL schedule must match the total reported on Lines 1 and 2 of the Cost report. If these two schedules do not match, the MO_RATES model has a message box that appears informing the user that the two schedules are out of balance. The message box will appear when the model is being saved and when the Check Totals menu option is selected. If the message box appears during the File Saving routine, click on the OK button and the Model will complete the Save routine. Please verify that the PERSONNEL schedule matches the amounts reported on Lines 1 and 2, prior to exporting data.

Note for Medicaid Contracts - The expenses reported on Line 1 must match the amount of salaries reported on lines 31 through 34 on the PERSONNEL schedule. The DSS is requiring all Medicaid substitute care contracts to classify and report their program salaries into the categories of MHP, QMHP, QMRP and RSA.

Line 2. Program Clerical Staff Salaries

The costs of clerical staff to type case notes and otherwise maintain specific client files. General clerical duties not performed specifically for a client should be reported in the administrative cost section.

Generally, an allocation of clerical staff costs based on job duties will be necessary to assign a portion of clerical staff costs to this line.

Contracted staff, including contracted temporaries should be reported on line 4.

Line 3. Program Staff Payroll Taxes and Fringe Benefits

The portion of the cost of payroll taxes and fringe benefits allocated to Program Staff reported in line 1 and 2. These costs include Employee Health and Retirement Benefits paid by an agency under its own or other employee health and retirement benefit plan. Payroll Taxes are the sum of the social security and other taxes payable by the employer under federal, state, or local law. Worker's Compensation Insurance. Other Employee Benefits provided to the employee at employer expense.

Line 4. Program Consultants

Program consultants include those providing the following services: Vocational Services, Academic Instruction, Speech and Language Services, Occupational and Physical Therapy, Psycho/Social Services, Medical Care, Recreational Services and Habilitation/Personal Care.

The amount reported on Line 4 must match the total amount of costs reported on the contractual worksheet. If these two amounts do not match, an error box will appear on the screen during the Save routine and during the Check Totals routine.

Line 5. Consumer Wages and Fringe Benefits

This represents the cost of paying wages and benefits to clients enrolled in the program. This should not be confused with Specific Assistance costs, which are reported elsewhere.

Line 6. Medicine and Drugs

The costs of medicine and drug supplies which are later separately reimbursed by Medicaid or other State agency should also be reported on line 47 'Non-reimbursable Expenses, Other'.

Line 7. All Other Direct Service Equipment and Supplies

The cost of program related materials and other supplies used by an agency. Items costing more than $500 with a useful life of more than one year must be capitalized and depreciated. Such depreciation costs would be reported on line 27.

Line 8. Staff Transportation

The object cost of operating vehicles associated with the travel of staff to or from client visits, court appearances, collateral contacts, offsite counseling/homemaker sessions or other similar activities. The costs may include vehicle insurance, license plates, gasoline and repairs and maintenance, or mileage reimbursement for use of personal cars.

Line 9. Client Transportation

The object cost of operating vehicles associated with transporting clients to parental visits, court appearances, counseling/therapy sessions or other similar activities. The costs may include vehicle

insurance, license plates, gasoline and repairs and maintenance, or mileage reimbursement for use of personal cars. Transportation costs which could be reasonably reported on either line 8 or 9 should be reported on line 9.

Line 10. Transportation To/From School

Solely the cost of transporting children to or from school. This line would typically be completed only for programs operating a day or boarding school. On the previous version of the MO RATES, this cost was not reported separately except to the Purchased Care Review Board

Line 11. Direct Service Staff Conferences and Conventions

The costs incurred through participation of program staff in training programs. The cost of conferences and conventions may be included here if agency program staff were participating.

Line 12. Program Insurance

The costs of all liability, malpractice, personal injury and other types of insurance not reported as property insurance or as employee benefits. The expense of malpractice insurance covering employees, consultants, and members of the board of directors while working in funded programs is allowable.

Amounts paid for key-man life insurance and unallowable malpractice (Unallowable malpractice insurance costs are those costs for covering individuals when working outside the funded program.) should be reported here. They should also be reported on line 47.

Line 13. Direct Client Specific Assistance

The object cost of providing individual clients with special needs where the items purchased become the property of the individual rather than the agency. Client allowances are also reported here.

Line 14. Telecommunications Costs Assigned to Program

The portion of the total telephone expense that is associated with utilization by either clients in their living quarters or by direct service staff. The remaining portion of the total telephone costs is reported in the Administrative Expense section.

Line 15. Foster Care Payments

Payments made from the provider agency to the foster parent for foster care services. This is commonly referred to as the 'Board Payment'.

Line 16. Other (specify)

Other program costs not logically reported in the above lines. "Other (specify)" can be typed over to identify the expense category.

Line 17. Total Program Expenses

The total of lines 1 through 16. The amount displayed in this cell is calculated by the spreadsheet. The cell is protected and cannot be changed.

SECTION 2. SUPPORT EXPENSE DEFINITIONS

Support expenses are all costs that are associated with providing meals and housekeeping services.

Line 18. Support Salaries

The accrued salary cost associated with dietary, laundry, housekeeping and security staff. Do NOT report contracted staff or consultants on this line. Contracted staff are reported on line 22.

Line 19. Support Staff Payroll Taxes and Fringe Benefits

The portion of the cost of payroll taxes and fringe benefits allocated to Support Staff reported in line 18. These costs include Employee Health and Retirement Benefits paid by an agency under its own or other employee health and retirement benefit plan. Payroll Taxes are the sum of the social security and other taxes payable by the employer under federal, state, or local law. And, Worker's Compensation Insurance

Line 20. Dietary Supplies

Costs included here would be those supplies related to food and beverages, and other kitchen supplies. Non-capitalized kitchen equipment expensed within the guidelines should also be included here.

Line 21. Housekeeping and Laundry Supplies

Costs included here would be housekeeping supplies and laundry and linen supplies.

Line 22. Other (specify)

Include contracted support services. This could typically include contracted food services or contracted housekeeping staff. "Other (specify)" can be typed over to identify the expense category. Other support costs not logically reported in the above lines.

Line 23. Total Support Expense

The total of lines 18 through 22. The model calculates the amount displayed in this cell. The cell is protected and cannot be changed.

SECTION 3. OCCUPANCY EXPENSE DEFINITIONS

Occupancy expenses are all costs arising from an agency's occupancy and use of land, buildings and offices. This includes maintenance salaries, depreciation on buildings, interest and lease costs.

All comprehensive hazard insurance including property liability insurance is here. To the degree possible, staff liability costs included in umbrella policies should not be reported under occupancy, but on line 12, 'Program Insurance'.

Line 24. Occupancy Salaries

The salaries and wages earned by an agency's regular employees (full or part-time and by temporary employees) providing facility maintenance and related services. These staff is employees who make repairs and generally keep the physical plant in operating condition including engineers.

Do NOT report contracted staff or consultants on this line. Contracted maintenance staff should be reported on line 34 below.

Salaries and wages should include vacation, holiday, or sick pay, and any employee authorized deductions. As previously stated, do not include the amount paid to consultants and others engaged on a contractual basis.

Line 25. Occupancy Payroll Taxes and Fringe Benefits

The portion of the cost of payroll taxes and fringe benefits allocated to Maintenance Staff. These costs include Employee Health and Retirement Benefits that is the amount paid by an agency under its own or other employee health and retirement benefit plan. Payroll Taxes are the sum of the social security and other taxes payable by the employer under federal, state, or local law. Worker's Compensation Insurance. In addition, other Employee Benefits including any other benefits provided to the employee at employer expense.

Line 26. Building and Equipment Operations and Maintenance

The general physical plant operation and maintenance costs. Typically, this would include the following object costs: Janitorial and Other Maintenance Supplies Building and Grounds Maintenance Supplies Equipment Maintenance Electricity, and, Utilities Property / Building Insurance.

Line 27. Vehicle Depreciation

The cost of vehicle purchases less applicable salvage value over their established useful lives. (Usually over a 3-year period.) If you used an accelerated depreciation method, the dollar amount of the accelerated depreciation, which exceeds the amount that would be calculated using the straight-line method, should be reported on line 47 in the non-allowable cost section.

Line 28. All other Depreciation and Amortization

The allocation of the cost of physical assets over their established useful lives. (Note that vehicle depreciation is reported separately on line 27 above.) Provision for depreciation is intended to spread

the cost of such assets over the periods their use benefits the program or supporting activities of the agency. If you used an accelerated depreciation method, the dollar amount of the accelerated depreciation, which exceeds the amount that would be calculated using the straight-line method, should be reported on line 47 in the non-allowable cost section.

Line 29. Vehicle Rent

The cost of rented or leased vehicles.

Line 30. All other Lease/Rent/Taxes

The cost of leasing property and equipment excluding vehicle rent expenditures reported on line 29 above. Property taxes are also reported on this line.

Line 31. Equipment under $500

Expensed Building Equipment and Furnishings (Assets costing more than $500 must be capitalized.)

Line 32. Mortgage and Installment Interest

Mortgage and installment interest is the cost of borrowing money for long term building needs. Note that the interest costs on funds borrowed for construction incurred during the construction period must be capitalized as a part of the building cost and depreciated over the life of the building. (Operating interest is reported on line 33 below.)

Line 33. Operating Interest

Operating interest is the cost of money borrowed to meet short term recurring spending needs such as payroll, telephone bills etc. (Non-operating interest is reported on line 32 above.)

Line 34. Other (specify)

Includes all ownership costs not identified above. This would include but is not limited to contracted facility maintenance and related services as well as required mortgage insurance. These contractors make repairs and generally keep the physical plant in operating condition including contracted engineers. "Other (specify)" can be typed over to identify the expense category.

Line 35. Total Occupancy Expense

The total of lines 24 through 34. The model calculates the amount displayed in this cell. The cell is protected and cannot be changed.

SECTION 4. ADMINISTRATIVE EXPENSE DEFINITIONS

Administrative expenses include direct program administration costs plus management and general costs. Program administration costs are those expenses that are caused by activities not related to an individual case, but related to running the overall program (and distinguished from support and occupancy costs). Management and general costs are defined below.

Line 36. Administrative Salaries

The accrued salaries and wages earned by all administrative, managerial office and clerical employees (except for those clerical employees reported on line 2 in the program section). Typical positions include the administrator, assistant administrator, accountants/bookkeepers and administrative clerical titles. Do NOT report contracted staff or consultants on this line. Contracted staff, including contracted temporaries should be reported on line 38.

Line 37. Administrative Payroll Taxes and Fringe Benefits

The portion of the cost of payroll taxes and fringe benefits allocated to Administrative Staff reported in line 36. These costs include Employee Health and Retirement Benefits paid by an agency under its own or other employee health and retirement benefit plan. Payroll Taxes are the sum of the social security and other taxes payable by the employer under federal, state, or local law. Worker's Compensation Insurance. And, Other Employee Benefits provided to the employee at employer expense.

Line 38. Administrative Consultants

Administrative consultants would include those fulfilling the following administrative functions: administrator, assistant administrator, accountants/bookkeepers and administrative clerical titles.

Line 39. Telecommunications Costs - Not Assigned to Program

The administrative telecommunications costs. This would include all telephone expenses that are not associated with utilization by either clients in their living quarters or by direct service staff.

The portion of the total telephone expense that is associated with utilization by either clients in their living quarters or by direct service staff is reported on line 14 in the program cost section.

Line 40. Office Supplies & Equipment

The costs of administrative office supplies and expensed equipment. The cost associated with staff recruiting activities should be reported on this line. The costs of conferences and conventions primarily benefiting administrative staff should also be reported on this line.

Line 41. Allocation of Management and General (G&A)

Management and General (also referred to as General and Administrative) expenses are those administrative expenses that are not part of any one program, but are caused by services to all programs run by an agency. Examples are the salaries of executive staff in a large agency, business office expense, and the non-personnel expenses for those people (such as the cost of the office space and telephones those people use).

Because management and general expense is a separate category, it is reported separately in an audit which breaks out expense by program. Audits treat it like a separate program.

Management and general expenses must be allocated to programs in proportion to the management and general services received by each program. This is done by an allocation method. Acceptable allocation methods include: (1) time studies in which people report the proportion of time spent on each program, and, (2) a formula: the proportion of direct service salaries and fringe benefits in all direct programs. This formula apportions or allocates a fair share of management and general costs to each program. Unacceptable methods include: guessing, units of service in this program divided by units of service in all programs, and allocation of management and general expenses to the programs where they will most likely be paid by the State.

Alternative Method of Reporting Management and General Costs

As an alternative to reporting management and general costs in this line, the costs that comprise management and general may be allocated vertically to the various line items. As an example, the rental cost of the business office that may be a component of total management and general costs could be alternatively reported on line 30 'All Other Lease/Rent/Taxes'. Likewise the other costs that comprise management and general costs could be similarly allocated among the line items.

Any allowable related party costs should be reported here. Please refer to the non-allowable cost definitions for a complete definition of allowable and non-allowable related party costs.

Line 42. Other (specify)

All other administrative costs not already reported. Included here would be: subscriptions and reference materials, postage and shipping, outside printing and artwork, conferences, conventions and meetings not reported in line 11, moving and recruiting, and office supplies.

The allowable portion of membership dues is also reported here. Please refer to the non-allowable cost instructions for the criteria under which a portion of membership dues may be allowable. "Other (specify)" can be typed over to identify the expanse category.

Line 43. Total Administrative Expenses

The total of lines 36 through 42. The model calculates the amount displayed in this cell. The cell is protected and cannot be changed.

Line 44. Total Expenses (Sum Lines 17, 23, 35, 43)

The total reported expenses. The model calculates the amount displayed in this cell. The cell is protected and cannot be changed.

PLEASE NOTE THAT THESE ARE THE TOTAL COSTS. THIS INCLUDES NONREIMBURSABLE EXPENSES. THE NON-REIMBURSABLE EXPENSES ARE AGAIN REPORTED ON LINES 45 THROUGH 48 WHERE THEY ARE DEDUCTED FROM THE TOTAL EXPENSES TO RESULT IN THE NET EXPENSES CALCULATED ON LINE 49.

SECTION 5. NON-REIMBURSABLE EXPENSES

This section describes those items that are classified as non-reimbursable by the State of Missouri. These costs have already been reported on lines 1 through 44. They should again be reported in the non-reimbursable costs section.

Line 45: Costs of Production and Workshop Client Wages Included Above

Costs of production include any costs incurred for the sale of goods and services. Costs of production include staff salaries and wages, staff fringe benefits, client salaries and wages, client fringe benefits, consultants, contractual workers, consumable supplies, occupancy, transportation, expensed equipment purchases, lease/rent, interest, depreciation, and other miscellaneous expenses. Cost of production may be reported in Regular Work, Vocational Development, and Developmental Training. The portion of expenses that have already been reported that fall within this classification should also be reported here.

For State funded vocational programs or developmental training (DT) programs, the expense of clients' wages is not reimbursable when the product or service is salable. Client wages and fringe benefits, if any, which are not related to the salable products and services may be reported on line 16 'Program Expenses, Other'.

Line 46. Fund Raising Activities

The state does not consider revenues from or the costs of fund raising activities in calculating rates.

Line 47. Other Unallowed Costs

THE FOLLOWING LISTS OF COSTS ARE NOT REIMBURSED BY THE STATE. THEY SHOULD BE REPORTED, UNLESS OTHERWISE SPECIFIED BELOW, IN AGGREGATE ON LINE 47 OF THE COST REPORT. These costs have already been reported on lines 1 through 44. They should again be reported in the non-reimbursable costs section and thereby removed from the costs rate calculation.

Insurance

A. Owner or Key-Man Life Insurance: Include on line 46 the expense of any life insurance policy in which the facility is named beneficiary and the life insurance is not generally available to all employees or all professional employees. If employees are provided life insurance proportionate to their salary and the owner or key-man has a policy under this option, that cost will not be reported here. That allowable cost should rather be reported as a fringe benefit in the allowable cost section.

B. Malpractice Insurance: The expense of malpractice insurance covering employees, consultants, and members of the board of directors, while working in funded programs is allowable. Any malpractice insurance expense, which would cover individuals when working outside of the funded program, is not allowable and such expense should be included on line 47.

Non Straight-Line Depreciation

Only straight-line depreciation is allowable for cost reporting and reimbursement calculation purposes. The amount of depreciation costs reported on lines 27 or 28 attributable to an accelerated depreciation method that exceeds the straight-line amounts should be included on line 47.

Legal Fees

The following are non-allowable legal fees: Legal fees incurred on behalf of individual clients unless they are specifically approved by the appropriate state agency. Non-program related activities. Litigation fees against governmental agencies. These non-allowable costs should be reported together on line 46 with other nonreimbursable expenses:

Trust Fees Trust fees are not allowable and should be included on line 47.
Interest Expense The following items of interest expense are not allowable and should be reported on line 47. Interest expense that is not necessary and proper for operation of the agency for rendering service. Funds borrowed for the personal benefit of employees, officers, or owners of the agency. Funds borrowed for investment purposes. And, Interest expense resulting from funds borrowed from related parties.

Intra-Agency Fund Loan Charges

Interest costs on transfers within an agency are not allowable. The related expense should be included on line 47.

Director's Fees

Board of Directors' fees is not allowable and should also be included on line 47. Reasonable expenses for board members to attend board meetings are allowable and should be reported in the allowable cost section within 'Other Administration'.

Related Organization Cost Adjustment

Related parties are defined as affiliates of the enterprise; entities for which investments are accounted for by the equity method by the enterprise; trusts for the benefit of employees, such as pension and profit sharing trusts that are managed by or under the trusteeship of management; principal owners of the enterprise; its management; members of the immediate families of principal owners of the enterprise and its management; and other parties with which the enterprise may deal if one party controls or can significantly influence the management or operating policies of the other to the extent that one of the transacting parties might be prevented from fully pursuing its own separate interests. Another party is a related party if it can significantly influence the management or operating polices of the transacting parties or if it has an ownership interest in one of the transacting parties and can significantly influence the other to an extent that one or more of the transacting parties might be prevented from fully pursuing its own separate interests.

The expenses resulting from transactions with related parties and/or parent organizations that are greater than the expense to the related party are not allowable. The unallowable portion of related party costs should be reported on line 47.

Depending upon the funding source, failure to disclose a related party transaction is a violation of either applicable law or rules, and is always a violation of professional ethics. Supporting documentation of related organization costs must be available for review upon request.

Amortization of Pre-Operating/Organizing Expense

Organization and pre-operating costs beyond the allowable levels should be reported on line 47.

Allowable Amortization of Organization and Pre-operating Costs

The cost of organizing the facility prior to operation is allowable only if amortized over at least a five-year period using the straight-line method of amortization. Other pre-operating costs are allowable if amortized (straight-line) over a five year period. Organization costs include those costs that are directly incidental to the formation of a corporation, other form of business or program. Allowable organization costs include such items as legal fees, accounting fees, incorporation fees, expenses of directors, and the expense of direct service staff training immediately prior to opening the program.

Allowable pre-operating expenses are those operating expenses which are incurred in making preparation for rendering client care before the first client is admitted. These costs should be capitalized and amortized over a 5-year period beginning when the first client is admitted.

Facility planning costs such as feasibility and engineering studies, architect fees, consultant fees and provider staff time should be added to the cost of the building and depreciated with other building costs over the estimated useful life of the building. Similarly, interest costs on funds borrowed for construction incurred during the construction period must be capitalized as a part of the building costs and depreciated over the useful life of the building.

Management Consultant Services

Management consultant service expenses are not allowable when:

Provided by employees already on the payroll.
Occurring as a part of pre-operating activities unless the costs are necessary and incidental to the formation of a new corporation, other form of business, or new program and occurred immediately before the opening of the program.
The non-allowable management consultant services should be identified on line 47.

Non-Client Occupancy Expense

Housing of non-clients is generally not allowable. However, if housing is being provided as part of a person's total remuneration package its value should be included as salary or fringe benefits as it is considered allowable. Non-allowable occupancy costs should be included on line 47.

Non-Client Meals

The expense of providing meals to guests and all non-program staff are non-allowable and should be included on line 47.

Printing Expense

Printing expenses that are related to fund-raising activities are non-allowable and should be included on line 47.

Advertising
Only advertising for staff recruitment, the solicitation of bids, and certain types of outreach are allowable.

Advertising related to fund raising activities is not an allowable cost. Any advertising costs for the purpose of increasing utilization are not allowable. Advertising expense for client outreach is allowable only if the licensing authority or major government funding authority requires an outreach component. These non-allowable costs should be included on line 47.

Bad Debts and Collection Fees
Bad debt expense and collection fees are not allowable and should be included on line 47.

Entertainment

Report on line 47 the expense of entertaining with meals, lodging, parties, and other forms of entertainment since it is not allowable. This does not include parties for clients, which are a part of program activity expenses.

Discounts, Allowances, Rebates

Discounts, allowances and rebates received must be deducted from expenses because they represent cost offsets and thus are not allowable. Any reported cost of discounts, allowances and rebates must be included on line 47.

Contributions, Donations, and Awards

All contributions, donations and awards made by the facility are non-allowable. The costs should be included on Line 47. (This refers to the expense of any agency rather than the income.)

Fines, Penalties and Late Fees

All fines, penalties and late fees are non-allowable. As such, they should be included on line 47.

Mortgage and Loan Principal Payment

Mortgage and loan principal payments should NOT be reported in the occupancy section. Expenditures for major asset purchases are disclosed on the cost report through depreciation and interest costs reported on lines 27, 28 and 32.

Research Expenses

Research expenses are not allowable. This does not include the cost of program evaluation that is allowable. Program evaluation is the systematic examination of the effectiveness of specific program activities of the agency and is directed toward assessing the need to modify those activities. Pre-approved research that is a component of the contract is reimbursable. Non-allowable research expenses should be included on line 47.

Contingencies

Contributions to a contingency reserve or any similar provision for unforeseen events are not allowable and should be included on line 47.

Losses on Other Grants and Contracts

If losses on other grants and contracts have been recorded as an expense, they must be included on line 47 together with other non-reimbursable costs. Losses on other grants or contracts are not an allowable expense.

Bidding or Proposal Costs

Expense relating to the development of bids or proposals is not allowable. Bidding or proposal costs should be included on line 47.

Patent/Copyright Cost

Expenses relating to patents and copyrights are non-allowable. They should be included on line 47.

Rented Facility Space

This should not be confused with allowable program rent costs. Unallowable expenses are those that are associated with the rental of any portion of the building to others. Unallowable expenses may include, but are not being limited to, building costs, telephones, utilities, office and janitorial services and supplies, etc. The costs of advertising, bookkeeping, rent collection, etc. which are associated with the rental are also not allowable. Include these non-allowable costs on line 47.

Non-Working Officer's Salary

Include on line 47 the full amount paid to officers working less than an average of one hour per week for the facility.

Compensation to Non-Working Owners

Include on line 47 the full amount paid to owners working less than an average of one hour per week for the facility.

Severance Pay

Severance pay is allowable only if required by contract or written personnel policy. Include any severance pay costs not meeting such requirements on line 47.

Income Taxes

Federal and state income taxes are not allowable expenses. Include these costs on line 47.

Sales Tax

Sales tax on food and other direct client care supplies is generally not allowable. However, sales tax is an allowable expense only for proprietary agencies. Include on line 47 the unallowable cost of sales tax.

Costs for a Period Other Than the Cost-Reporting Period

Costs for a period other than the cost reporting period are not allowable. These costs should be included on line 47.

Costs Resulting from a Sale And Leaseback Transaction

The costs of a leaseback transaction that exceeds the depreciation costs of the asset are not allowable. The costs of the transaction that exceed the depreciation costs of the asset should be included on line 47.

Special Benefits

The cost of benefits provided to owners that is not provided to all full-time employees is not allowable. These costs should be included in line 47.

Legal Retainers

The cost of legal retainers is not allowable. The cost should be included in line 47.

Lobbying and Contributions

The costs associated with lobbying efforts as well as political contributions are not allowable. The cost should be included in line 47.

Costs That Are Separately Reimbursed

This generally refers to supplies and services within a program, which are reimbursed by a funding source other than the State agency responsible for the cost and rate analysis. For example, Medicaid (through Medical Services) often reimburses the cost of drugs prescribed for a client. That amount of the reimbursement from DMS should be reported here as an offset to the total cost reported in line 6.

Other Costs Not Reasonably Related To Services

Other costs reported on the audit report but not reasonably related to program costs should be included on line 47. Examples of these types of other non-allowable costs would include: Theft, non-medicinal alcohol, and luxury autos.

THE FOLLOWING COSTS MAY OR MAY NOT BE REIMBURSED BY THE STATE DEPENDING ON THE FUNDING AGENCY'S RULES AND PROCEDURES.

Assistance to Individuals

Assistance to clients in the form of clothing, allowance, or supplies that become property of the

clients should be reported on line 13. Do NOT report these costs again on line 47. Generally, these items are the responsibility of the parents.

Membership Dues and Fees

Generally, membership dues are not allowable and should be reported on line 47

REVENUE

Revenues are generally broken out by revenue source. PLEASE NOTE THE SEPARATE LINE (13) FOR REPORTING SPECIAL SERVICE FEE FOR INDIVIDUAL CLIENTS' REVENUES.

SECTION 1. FEES & PURCHASE OF SERVICE

Payments made for specific individuals for a specific program/service. Usually for service provided at a specific date and time or continuously over a period of enrollment. Payments may be from a public or private source including units of government, education, individuals, or third-party payers. Includes payments assessed to an individual or family receiving the service such as fees/sliding fees, and assessments against pensions, Social Security, Supplemental Security, food stamps, survivor benefits, insurance, etc. Also includes specific fees for add-on services provided within a larger program context (e.g. add-on fees for one-on -one aides.)

SECTION 2. GRANT REVENUES

Funding awarded toward full or partial support of a specific program/service, or agency, or facility serving an identified or targeted population. Funding may be provided by a public or private source including units of government, education, individuals or foundations.

SECTION 3. CONTRIBUTIONS & OTHER

A. Contributions, gifts, endowments, transfers of assets, donations of monies, goods, or services. Contributions may be specifically restricted by the donor, or unrestricted.

B. Revenue from sales of goods and services or assets, income from rental of property to others, income from cafeteria and vending machines.

SECTION 4. INVESTMENT INCOME

Interest earnings on assets and investments including those that are donor restricted as well as those that are restricted.

SECTION 5. NET ASSETS RELEASED FROM RESTRICTION

Assets that were previously restricted which have now converted to discretionary use.

REPORT OF SERVICE UNITS/DAYS/NIGHTS

For Grant funded programs, report Service Unit Type as defined in the grant document. Examples might be: 'Monthly', 'Quarterly', 'Annual', 'Daily', or 'Hourly'. Also for Grant funded programs, report the number of service units provided in total as well as a separate number for DSS only service units.

For programs funded through purchase of service or fees for service, report the actual number of units or days of service delivered in total and for DSS only.

The number of days the program operated is then reported. For example, a program that was in operation for a full year and is reporting a full year of operations would report 365 days. For reporting purposes here, count holidays and weekends as working days.

If the program is licensed and has a licensed capacity, identify the licensed capacity at the beginning of the reporting period and at the end of the reporting period. If a change has occurred in the capacity, the date of the change should be reported. The date of change should be formatted as mm-dd-yyyy. The dashes between the month, day and year are important for the date to be properly formatted. Also, note that the year is formatted for 4 digits (1998).

PERSONNEL

INSTRUCTIONS FOR THE STANDARD SALARY SUPPLEMENTAL SCHEDULE

Position Column

Not all positions at an agency are listed here. The only positions listed are those that are necessary to support rate computations, federal claiming calculations or other data collection needs. Positions not listed should be reported on line 29 only if they are classified as program staff. The totals of all positions reported here should match the total on line 1 and 2 of the Cost schedule.

The position column lists staff positions for which there are a set of uniform job descriptions. The position descriptions are intended to be functional in nature. Therefore, staff reasonably fitting into job descriptions should be reported under the associated position title. The position descriptions are largely based on those used by the United Way of Chicago. A description of each position is included at the end of these instructions.

Total Hours

Record the total number of hours paid and accrued including overtime hours for each position title filled during the year, or any portion thereof. Paid vacation, holidays and sick time are included in the sum of hours paid and accrued. (Because salaried positions are not paid for overtime, record only the non-overtime hours worked.)

Total Amount Paid

Record the total dollars paid and accrued including overtime hours for each position title filled during the year, or any portion thereof. Paid vacation, holidays and sick time are included in the sum of amounts paid and accrued.

For example, assume the following caseworker staffing history for an agency with a standard eight-hour day and 260 working days in a year:

Name	Period on Staff	Work Days	Work Hours	Wages Paid
Craig	7/1/95 - 6/30/96	260	2,080	$24,960
Tom	7/1/95 - 6/30/96	260	2,080	$24,960
Andy	4/1/96 - 6/30/96	65	520	$6,240
Roger	7/1/95 - 10/31/96	87	696	$8,352
Nyle	7/1/95 - 5/30/96	239	1,912	$22,944
	TOTALS		7,288	$87,456

In this example, 7,288 hours were paid. The 7,288 would be reported in the 'Total Hours' column. $87,456 would be reported in the 'Total Amount Paid' column.

Total Head Count

Record the end of year head count in that salary position. Part-time staff or staff allocated between differing positions or programs would be counted more than once. For example, a staff person working mornings in a group home program and afternoons in a counseling program would be counted as 1 in the group home program and 1 in the counseling program. Using the previous example, only Craig, Tom and Andy were present at the end of the reporting period. Therefore, the head count would be reported as 3.

% Allocated

This column is calculated by the software for you based on the proportion of salaries entered across programs.

Salaries and Wages (Under the Program Headings)

Enter the dollars allocated to each program for salary and wage costs under the proper program headings and within the appropriate position description lines. Number of Hours in a Standard Work Week Identify the number hours in a normal workweek. For example, if the work day begins at 8:30 and ends at 5:00 with a one-hour lunch between, the workday is 7 1/2 hours long. Therefore, if the normal workweek consists of $37^{1/2}$ hours, record 37.5 in this box.

DESCRIPTION OF PROGRAM/CONTRACTUAL STAFF POSITIONS

Audiologist

Report credentialed audiologists on this line.

Behavior Therapist

Worker who develops behavioral therapies and programs usually for direct care workers to carry out. Position may be credentialed. (Licensed, certified, and registered)

Dietary Technician

A worker who carries out special dietary programs and recommendations of dietician, may include food preparation. Does not include direct care workers classified elsewhere.

Dietician

Credentialed worker who assesses dietary needs of individuals and makes dietary and feeding recommendations, designs diets, and dietary programs, monitors dietary programs and their delivery, participates in annual individual habilitation or rehabilitation planning.

Habilitation Aid / Child Care Worker

Workers whose primary functions include the provision of hands-on, face-to-face contact with the clients. This includes day, residential, live-in/sleep-over staff, and respite care workers. It excludes foster parents, managers, supervisors and administrative staff, professional staff who are credentialed (licensed), and production-oriented workers.

Habilitation Professional or Supervisory Staff

Workers not classified elsewhere who are credentialed (licensed, registered, and certified) or whose responsibilities are direct service supervisory.

LPN

Report Registered Licensed Practical Nurses on this line.

Mental Health Professional (MHP)

Provides services under the supervision of a qualified mental health professional. The mental health professional must possess a bachelor's degree, a practical nurse license, or have a minimum of five years experience in mental health or human services.

Occupational Therapist

Report Registered Credentialed Occupational Therapist on this line.

Physical Therapist

Report Registered Credentialed Physical Therapist on this line.

Physician

Report Registered Credentialed Physician on this line

Principal

Report the Chief administrator of the education program on this line.

Program Director

Overall program director. Depending on size and structure of the agency, this person may function only as an administrator or may also have direct programmatic duties, such as counselors' supervisor, utilization review, case review, and may carry a clinical caseload. Costs may therefore be split between program and administration lines in the expense reports. If there is a programmatic

function performed by this person, then the associated hours and wages allocated to program functions are to be reported here.

Program Clerical Staff

Clerical staff that performs clinical record keeping, client appointment tracking, and case note typing, and filing.

Psychiatrist

Report Registered Credentialed Psychiatrist on the Psychologist line.

Psychologist

Report Registered Credentialed Psychologist on the Qualified Mental Health Professional (QMHP) line, which would include the following:

A. A physician licensed to practice medicine or osteopathy with training in mental health services or 1 year of clinical experience, under supervision, in treating problems related to mental illness, or specialized training in the treatment of children and adolescents.

B. A psychiatrist who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by the State of Missouri.

C. A licensed psychologist with specialized training in mental health services.

D. A licensed social worker possessing a master's or doctoral degree in social work with specialized training in mental health services.

E. A licensed registered nurse with at least 1 year of clinical experience in a mental health setting or a Master's Degree in psychiatric nursing.

F. A registered occupational therapist with at least 1 year of clinical experience in a mental health setting.

G. An individual possessing a master's or doctoral degree in counseling and guidance, rehabilitation counseling, or family therapy, or related field, who has successfully completed a practicum and / or internship which includes a minimum of 1,000 hours, or who has one year of clinical experience under the supervision of a qualified mental health professional, or who is a licensed social worker holding a master's degree with 2 years of experience in metal health services.

Qualified Mental Retardation Professional (QMRP)

A QMRP must have at least 1 year of experience working directly with individuals with mental retardation or other developmental disabilities and be one of the following:

A. A licensed doctor of medicine or osteopathy.

B. A licensed registered nurse.

C. A certified occupational therapist or occupational therapist assistant.

D. A certified physical therapist.

E. A registered physical therapist assistant or a graduate of a 2-year college-level program approved by the American Physical Therapy Association or comparable body.

F. A psychologist with at least a master's degree in psychology from an accredited school.

G. A social worker with a bachelor's degree from a college or university or graduate degree from a school of social work accredited or approved by the Council on Social Work Education or other comparable body.

H. A speech-language pathologist or audiologist with a certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech Language Hearing Association or comparable body or meeting the education requirements of licensure and be in the process of accumulating the supervised experience required for licensure.

I. A professional recreation staff person with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical therapy.

J. A professional dietician registered by the American Dietetics Association. Or,

K. A human services professional with a bachelor's degree in a human services field, including, but not limited to, sociology, special education, rehabilitation counseling or psychology.

Rehabilitative Services Associate (RSA)

Assists in provision of services in accordance with MRO Rules, Sections 132.155 and 132.170. Must be at least 21 years old, have demonstrated skills in the field of services to children, have demonstrated ability to work within agency structure and accept supervision, have demonstrated ability to work constructively with clients, other providers and the community.

Recreation Staff

Report Recreation Director and Staff on this line.

RN

Report Registered Credentialed Nurse on this line

Social Worker

A licensed social worker possessing a master's or doctoral degree in social work with responsibility for application of social work skills.

Speech Therapist

Report Registered Credentialed Speech Therapist on this line.

Substance Abuse Counselor/Professional

Holds clinical certification as a Certified Alcohol and Drug Counselor and meets the requirements of Rule 2060.309 et seq.

Substance Abuse Paraprofessional
Direct service worker (e.g. counselor trainee, intake worker, night coverage in residential Rehabilitation) under supervision of the Substance Abuse Professional defined above.

Teacher

Teaches and works with children in an appropriate setting designed for the educational, social, and emotional development of children.

Teacher Aide

Staff working under the direct supervision of the teacher(s). Performs duties related to the care of children and operation of classrooms. May have limited responsibility for instruction.

Vocational Staff

Staff working in vocational training and education areas not producing goods or services for sale.

Other Academic

Those education or academic positions not better classified elsewhere.

Other Medical Care

Those medical positions not better classified elsewhere.

Other Habilitation/Rehabilitation

Those habilitation or rehabilitation positions not better classified elsewhere.

Other Substance Abuse

Those substance abuse positions not better classified elsewhere. Lines 31 through 34 are to be completed for Medicaid certified programs only. The definitions for these staff positions are included in the above listing. Note: The expenses reported on Line 31 through 34 must match the amount of salaries reported on line 1 of the COST schedule. All Medicaid residential care contracts must classify and report their program salaries into the categories of MHP, QMHP, QMRP and RSA.

INSTRUCTIONS FOR THE STANDARD CONSULTANT AND CONTRACTUAL SUPPLEMENTAL SCHEDULE

This schedule is completed simiarly to the Standard Salary Supplemental Schedule. However, the headcount information is not requested. The total amount must equal line 4 of the COST schedule.

AUTHORITY: section 207.020, RSMo 2000. Emergency rule filed Jan. 16, 2004, effective Jan. 26, 2004, expired July 23, 2004. Original rule filed Jan. 16, 2004. effective Aug. 30, 2004. Emergency amendment filed Sept. 22, 2004, effective Oct. 2, 2004, expired March 30, 2005. Amended: Filed Sept. 22, 2004, effective March 30, 2005. Emergency amendment filed June 15, 2005, effective July 1, 2005, expires Dec. 27, 2005. A proposed amendment covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 2—General Scope of Medical Service Coverage

EMERGENCY RESCISSION

13 CSR 70-2.020 Scope of Medical Services for General Relief Recipients. This rule provided for the scope of medical services which were covered by the Medicaid program for general relief assistance recipients.

PURPOSE: This rule is being rescinded because the eligibility category general relief, which granted Medicaid coverage to unemployed adults because of temporary or permanent disabilities, was not funded by the Missouri General Assembly beginning July 1, 2005.

EMERGENCY STATEMENT: This emergency rescission is necessary because the Missouri General Assembly did not appropriate money to make payments for medical assistance on behalf of those individuals who receive general relief benefits. Current state statute, section 208.162, RSMo 2000, requires "payments shall be prorated within the limits of the appropriation." This emergency rescission must be implemented on a timely basis, at the beginning of the state fiscal year, to ensure that the $13.2 million, that had been spent for medical services for general relief recipients, is available to provide services for the most needy Missourians for whom the 93rd General Assembly appropriated funds. A proposed rescission, which covers the same material, is published in the July 15, 2005 issue of the ***Missouri Register****. The scope of this emergency rescission is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The Division of Medical Services believes this emergency rescission is fair to all interested persons and parties under the circumstances. This emergency rescission was filed June 7, 2005, effective July 1, 2005, expires December 27, 2005.*

AUTHORITY: section 207.020, RSMo 1986. This rule was previously filed as 13 CSR 40-81.181. Emergency rule filed July 15, 1981, effective Aug. 1, 1981, expired Oct. 10, 1981. Original rule filed July 15, 1981, effective Oct. 11, 1981. Amended: Filed April 17, 1987, effective Sept 11, 1987. Emergency rescission filed June 7, 2005, effective July 1, 2005, expires Dec. 27, 2005. A proposed rescission covering this same material is published in this issue of the ***Missouri Register****.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 4—Conditions of Recipient Participation, Rights and Responsibilities

EMERGENCY AMENDMENT

13 CSR 70-4.090 Uninsured *[Parents']* ***Women's*** **Health** *[Insurance]* **Program**. The division is deleting sections (1), (3), (4), and (5), amending the rule title, the Purpose section and sections (2), (6), and (7) and renumbering sections as needed.

PURPOSE: This amendment eliminates payment for medical services for individuals losing extended transitional medical assistance from the Uninsured Parents' Health Insurance Program.

*PURPOSE: This rule establishes the Uninsured [Working Parents'] **Women's** Health [Insurance] Program. This program will provide payment for [health care coverage] **women's health services** for uninsured[, low income, working parents leaving welfare for work thereby reducing future dependence on welfare and reducing] **women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, in order to reduce** the possibility of a family's future dependence on welfare as authorized pursuant to section 208.040, RSMo. The program is also authorized pursuant to the award of the Missouri State Medicaid Section 1115 Health Care Reform Demonstration Proposal approved by the [Health Care Financing Administration] **Centers for Medicare and Medicaid Services**.*

EMERGENCY STATEMENT: Missouri's economic status requires emergency measures to contain cost wherever feasible. In order to meet SFY 2006 projected revenues, the 93rd General Assembly, in House Bill 11, approved savings. The 93rd General Assembly, House Bill 11, eliminated medical services for individuals receiving extended transitional medical assistance beginning July 1, 2005. State authority for the Division of Medical Services to make payments for medical services for individuals receiving extended transitional medical assistance is through appropriation. Promulgation of this emergency amendment is necessary to preserve the compelling governmental interest to achieve a balanced state budget for SFY 2006. Since the division has no state authority other than appropriation authority to make payments to individuals receiving extended medical assistance and now that authority has been removed from the State Fiscal Year 2006 budget beginning July 1, 2005, the division must act immediately to eliminate payments for individuals receiving extended transitional medical assistance. This emergency amendment must be implemented on a timely basis, at the beginning of the state fiscal year, to ensure that the $3.1 million, that had been spent for medical services for individuals eligible for extended transitional medical assistance, is available to provide services for the most needy Missourians for whom the 93rd General Assembly did appropriate funds. A proposed amendment, which covers the same material, is published in this issue of the ***Missouri Register****. The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the* ***Missouri*** *and* ***United States Constitutions****. The division believes this emergency amendment is fair to all interested persons and parties under the circumstances. This emergency amendment was filed June 7, 2005, effective July 1, 2005, expires December 27, 2005.*

[(1) Definitions.

(A) Health insurance. Any hospital and medical expense incurred policy, nonprofit health care service for benefits other than through an insurer, nonprofit health care service plan contract, health maintenance organization subscriber contract, preferred provider arrangement or contract, or any other similar contract or agreement for the provision of health care benefits. The term "health insurance" does not include short-term, accident, fixed indemnity, limited benefit or credit insurance coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be

contained in any liability insurance policy or equivalent self-insurance.

(B) Co-payment. A cost-sharing arrangement in which a covered person pays a specified charge for a specified service, such as ten dollars ($10) for a professional service.

(C) Parents. For purposes of this regulations the term parents refers to biological or adoptive parent(s).]

*[(2)]***(1)** *[The following uninsured individuals]* **Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage,** shall be eligible to receive medical services to the extent and in the manner provided in this regulation.*[:*

(A) Individuals losing transitional medical assistance (TMA) who would not otherwise be insured or Medicaid eligible, with net income at or below one hundred percent (100%) of the federal poverty level for the household size—

1. Eligibility for the Uninsured Parents' Health Insurance Program for individuals losing TMA ends twelve (12) months after TMA eligibility ends; and

2. After coverage ends, the individuals with a child eligible for MC+ have the option of staying in the MC+ health plan, where managed care is available, if the parents pay the cost of the state's cost for the time period covered by the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal as approved by the Health Care Financing Administration;

(B)] Uninsured women who do not qualify for other medical assistance benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage, will continue to be eligible for *[family planning and limited testing of sexually transmitted diseases (EWH),]* **women's health services only,** regardless of income, for twelve (12) consecutive months. **Women's health services are defined as: pelvic exams and pap tests, sexually transmitted disease testing and treatment (the treatments of medical complications occurring from the sexually transmitted disease are not covered for this program), family planning counseling/education on various methods of birth control, United States Department of Health and Human Services approved methods of contraception including sterilization and x-ray services related to the sterilization, and drugs (excluding antiretrovirals), supplies or devices related to the women's health services described in this rule when they are prescribed by a physician or advanced practice nurse, subject to the national drug rebate program requirements.**

[(3) Beneficiaries covered in section (2) of this rule shall be eligible for service(s) from the date their application is received. No service(s) will be covered prior to the date the application is received.]

[(4) The following services are covered for beneficiaries of the Uninsured Parents' Health Insurance Program if they are medically necessary:

(A) Inpatient hospital services;

(B) Outpatient hospital services;

(C) Emergency room services;

(D) Ambulatory surgical center, birthing center;

(E) Physician, advanced practice nurse, and certified nurse midwife services;

(F) Maternity benefits for inpatient hospital and certified nurse midwife. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo. A shorter length of hospital stay for services related to maternity and newborn care may be authorized if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law. The health plan is to provide coverage for post-discharge care to the mother and her newborn. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization and be documented in the patient's medical record. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two (2) visits at least one (1) of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physician assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests and submission of a metabolic specimen satisfactory to the state laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use;

(G) Family planning services;

(H) Pharmacy benefits;

(I) Dental services to treat trauma;

(J) Laboratory, radiology and other diagnostic services;

(K) Prenatal case management;

(L) Hearing aids and related services;

(M) Eye exams and services to treat trauma or disease (one (1) pair of glasses after cataract surgery only);

(N) Home health services;

(O) Emergent (ground or air) transportation;

(P) Non-emergent transportation only for members in ME Code 78 Parents' Fair Share;

(Q) Mental health and substance abuse services;

(R) Services of other providers when referred by the health plan's primary care provider;

(S) Hospice services;

(T) Durable medical equipment (including but not limited to: orthotic and prosthetic devices, respiratory equipment and oxygen, enteral and parenteral nutrition, wheelchairs and walkers, diabetes supplies and equipment);

(U) Diabetes self-management training for persons with gestational, Type I or Type II diabetes;

(V) Services provided by local health agencies (may be provided by the health plan or through an arrangement between the local health agency and the health plan)—

1. Screening, diagnosis, and treatment of sexually transmitted diseases;

2. HIV screening and diagnostic services;

3. Screening, diagnosis, and treatment of tuberculosis; and

(W) Emergency medical services. Emergency medical services are defined as those health care items and services furnished or required to evaluate or stabilize a sudden and unforseen situation or occurrence or a sudden onset of a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the failure to provide immediate medical attention could reasonably be expected by a prudent lay person, possessing average knowledge of health and medicine, to result in:

1. Placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part; or

4. Serious harm to a member or others due to an alcohol or drug abuse emergency; or

5. Injury to self or bodily harm to others; or

6. With respect to a pregnant woman who is having contractions: a) that there is inadequate time to effect a safe transfer to another hospital before delivery; or b) that transfer may pose a threat to the health or safety of the woman or the unborn child.]

[(5) Individuals losing TMA shall owe a ten dollar ($10) co-payment for certain professional services and a five dollar ($5) co-payment in addition to the recipient portion of the professional dispensing fee for pharmacy services required by 13 CSR 70-4.051.

(A) Providers may request payment of the mandatory co-payment(s) prior to or after service delivery.

(B) The co-payment amount shall be deducted from the Medicaid maximum allowable amount for fee-for-service claims reimbursed by the Division of Medical Services.

(C) Service(s) may not be denied for failure to pay the mandatory co-payment(s).

(D) When a mandatory co-payment is not paid, the Medicaid provider will have the following options:

1. Forego the co-payment entirely;

2. Make arrangements for future payment with the recipient; or

3. File a claim with the Division of Medical Services to report the non-payment of the mandatory co-payment(s) and secure payment for the service from the Division of Medical Services.

(E) When the Division of Medical Services receives a claim from a Medicaid fee-for-service provider for non-payment of the mandatory co-payment, the division shall send a notice to the recipient—

1. Requesting that the recipient reimburse the Division of Medical Services for the mandatory co-payment made on their behalf;

2. Requesting information from the recipient to determine if the mandatory co-payment was not made because there has been a change in the financial situation of the family; and

3. Advising the recipient of the possible loss of coverage for up to six (6) months if the recipient fails to pay three (3) co-payments in one (1) year.

(F) The recipient will be allowed fourteen (14) calendar days to respond. If the recipient indicated there has been a change in the financial situation of the family, the state shall redetermine eligibility—

1. If the eligibility redetermination places the recipient in a non-mandatory co-payment category, there will be no co-payment due; or

2. If the eligibility redetermination does not place the recipient in a non-mandatory co-payment category another notice will be sent to the recipient about the mandatory co-payment provision of the program which shall include the number of co-payments that have not been paid and how many may not be paid before a recipient is terminated from the program.

(G) Notice of non-payment of mandatory co-payment(s) sent to the recipient during the course of a year shall establish a pattern of not meeting the mandatory cost sharing requirement of the program. The process to terminate eligibility shall proceed with the third failure to pay a mandatory co-payment in any one (1) year or until one (1) or more of the three (3) delinquent mandatory co-payments is made. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months time whichever occurs first. Health care coverage shall not be retroactive.

1. A year starts at the time a co-payment is reported not paid to the Division of Medical Services;

2. Payment of a delinquent co-payment or co-payments will eliminate the failure to pay a mandatory co-payment or co-payments.

(H) Recipient(s) shall have access to a fair hearing process to appeal the disenrollment decision.

(I) If the recipient fails to pay the mandatory co-payments three (3) times within a year and is disenrolled from coverage the recipient shall not be eligible for coverage for six (6) months after the department provides notice to the recipient of disenrollment for failure to pay mandatory co-payments or until one (1) or more of the three (3) delinquent mandatory co-payments is paid. Coverage shall begin again only after payment of one (1) or more of the three (3) co-payments or passage of six (6) months whichever occurs first. Coverage shall not be retroactive.]

*[(6)]***(2)** Uninsured women who do not qualify for other benefits, and would lose their Medicaid eligibility sixty (60) days after the birth of their child or sixty (60) days after a miscarriage are not required to pay a co-payment for **women's health** services.

*[(7)]***(3)** The Department of Social Services, Division of Medical Services shall provide for granting an opportunity for a fair hearing to any applicant or recipient whose claim for benefits under the Missouri Medicaid Section 1115 Health Care Reform Demonstration Proposal is denied *[or disenrollment for failure to pay mandatory co-payments has been determined]* by the Division of Medical Services. There are established positions of state hearing officer within the Department of Social Services, Division of Legal Services in order to comply with all pertinent federal and state law and regulations. The state hearing officers shall have authority to conduct state level hearings of an appeal nature and shall serve as direct representative of the director of the Division of Medical Services.

*AUTHORITY: sections 208.040, RSMo Supp. [2001] **2004** and 208.201 and 660.017, RSMo 2000. Emergency rule filed Sept. 13, 1999, effective Sept. 23, 1999, terminated Oct. 15, 1999. Original rule filed Aug. 16, 1999, effective March 30, 2000. Amended: Filed March 29, 2001, effective Oct. 30, 2001. Emergency amendment filed June 7, 2002, effective July 1, 2002, expire[s]**d** Dec. 27, 2002. Amended: Filed June 11, 2002, effective Nov. 30, 2002. Emergency amendment filed June 7, 2005, effective July 1, 2005, expires Dec. 27, 2005. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
Chapter 15—Hospital Program

EMERGENCY AMENDMENT

13 CSR 70-15.110 Federal Reimbursement Allowance (FRA). The division is adding section (13).

PURPOSE: This amendment will establish the Federal Reimbursement Allowance (FRA) assessment for State Fiscal Year 2006 at five and fifty-four hundredths percent (5.54%).

*EMERGENCY STATEMENT: The 93rd General Assembly reauthorized the Federal Reimbursement Allowance (FRA) through September 30, 2006 by enacting House Committee Substitute for Senate Bill (HCS SB) 189. The reauthorization of the FRA requires every hospital as defined by section 197.020, RSMo, except public hospitals which are operated primarily for the care and treatment of mental disorders, and any hospital operated by the Department of Health and Senior Services to pay a federal reimbursement allowance for the privilege of engaging in the business of providing inpatient health care in this state. Because of the need to preserve state revenue, HCS SB 189 was deemed necessary for the immediate preservation of the public health, welfare, peace and safety, and was declared to be an emergency within the meaning of the constitution. HCS SB 189 was signed by the governor May 13, 2005. Because HCS HB 189 contains an emergency clause, its provisions became effective once the governor signed the bill on May 13, 2005. The Division of Medical Services finds that this emergency amendment to establish the FRA assessment rate for State Fiscal Year (SFY) 2006 in regulation, as required by state statute, is necessary to preserve a compelling governmental interest of collecting state revenue to provide health care to individuals eligible for the Medicaid program and the uninsured. An early effective date is required because the emergency amendment establishes the Federal Reimbursement Allowance rate for SFY 2006 in order to collect this state revenue beginning with the first Medicaid payroll for SFY 2006 to ensure access to hospital services for indigent and Medicaid recipients at hospitals which have relied on Medicaid payments in meeting those needs. The Division of Medical Services also finds an immediate danger to public health and welfare which requires emergency actions. If this emergency amendment is not enacted, there would be significant cash flow shortages causing a financial strain on all hospitals which service more than nine hundred thousand (900,000) Medicaid recipients. This financial strain will, in turn, result in an adverse impact on the health and welfare of those Medicaid recipients and the uninsured in need of medical treatment. On an annual basis the FRA raises approximately $709,765,443. A proposed amendment, which covers the same material, is published in this issue of the **Missouri Register**. This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Division of Medical Services believes this emergency amendment to be fair to all interested parties under the circumstances. The emergency amendment was filed June 7, 2005, effective June 17, 2005, expires December 13, 2005.*

(13) Federal Reimbursement Allowance (FRA) for State Fiscal Year 2006. The FRA assessment for State Fiscal Year (SFY) 2006 shall be determined at the rate of five and fifty-four hundredths percent (5.54%) of the hospital's total operating revenue less tax revenue/other government appropriations plus non-operating gains and losses as published by the Missouri Department of Health and Senior Services, Section of Health Statistics. The base financial data for 2002 will be annualized, if necessary, and will be adjusted by the trend factor listed in 13 CSR 70-15.010(3)(B) to determine revenues for the current state fiscal year. The financial data that is submitted by the hospitals to the Missouri Department of Health and Senior Services is required as part of 19 CSR 10-33.030 Reporting Financial Data by Hospitals. If the pertinent information is not available through the Department of Health and Senior Services' hospital database, the Division of Medical Services will use the Medicaid data similarly defined from the Medicaid cost report that is required to be submitted pursuant to 13 CSR 70-15.010(5)(A).

*AUTHORITY: sections 208.201, 208.453 and 208.455, RSMo 2000. Emergency rule filed Sept. 21, 1992, effective Oct. 1, 1992, expired Jan. 28, 1993. Emergency rule filed Jan. 15, 1993, effective Jan. 25, 1993, expired May 24, 1993. Original rule filed Sept. 21, 1992, effective June 7, 1993. For intervening history, please consult the **Code of State Regulations**. Emergency amendment filed June 7, 2005, effective June 17, 2005, expires Dec. 13, 2005. A proposed amendment covering this same material is published in this issue of the **Missouri Register**.*

Title 19—DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 60—Missouri Health Facilities Review Committee
Chapter 50—Certificate of Need Program

EMERGENCY AMENDMENT

19 CSR 60-50.430 Application Package. The Committee proposes to amend paragraph (4)(C)1. and section (6).

PURPOSE: This rule is amended because the Missouri CON Rulebook has been updated to include the 2010 population projections just released that are necessary to incorporate five (5)-year planning horizons.

EMERGENCY STATEMENT: This emergency amendment is necessary to preserve a compelling governmental interest in health care cost containment. It requires rewriting the CON rules in order to replace the 2005 outdated population information with the 2010 population projections. The CON statutes, sections 197.300 to 197.366, RSMo, were enacted to ensure the preservation of health care access, the prevention of unnecessary duplication, the containment of health care costs, and the reasonable distribution of health services in Missouri.

Therefore, the Missouri Health Facilities Review Committee (Committee) files this emergency amendment because it is necessary for the immediate preservation of the public health, safety, and welfare and to ensure health care access at a reasonable cost. The review process requires that applicants develop projects that meet a community need by using objective service area population projections five (5) years ahead that anticipate change by clusters of zip codes which represent the expected market area. These calculations are the foundation of need determination with substantial influence on the Committee's decision to approve or deny a Certificate of Need application.

The Committee believes this emergency amendment to be fair to all interested parties under these circumstances so that the Committee may give clear guidance to health care facilities, physicians, investors, and other prospective applicants for their planning purposes. Failure to immediately update the CON rules to provide reasonable and accurate population statistics for these applications would negatively impact the state's ability to forecast need, create a confusing regulatory environment for health care providers, and impair the Committee's ability to meet needs. The Committee wishes to reduce unnecessary applicant expense and time in the preparation of accurate market area forecasts, and to accurately meet the health care needs of Missouri without unnecessarily increasing health care costs.

*This emergency amendment limits its scope to the circumstances creating the emergency and complies with the protections extended by the **Missouri** and **United States Constitutions**. The Committee finds that an emergency amendment is necessary to preserve health care access, allow health care providers to use the latest objective population statistics, and prevent negative impacts to the public health,*

safety, and welfare of the citizens of Missouri. This emergency amendment was filed on June 8, 2005, to become effective on July 1, 2005, and will expire on December 30, 2005.

(4) The Proposal Description shall include documents which:

(C) Proposals for new hospitals, new or additional long-term care (LTC) beds, or new major medical equipment must define the community to be served:

1. Describe the service area(s) population using year *[2005]* **2010** populations and projections which are consistent with those provided by the Bureau of Health Data Analysis which can be obtained by contacting:

Chief, Bureau of Health Data Analysis
Center for Health Information Management and Evaluation
(CHIME)
Department of Health and Senior Services
PO Box 570, Jefferson City, MO 65102
Telephone: (573) 751-6278

There will be a charge for any of the information requested, and seven to fourteen (7–14) days should be allowed for a response from the CHIME. Information requests should be made to CHIME such that the response is received at least two (2) weeks before it is needed for incorporation into the CON application.

2. Use the maps and population data received from CHIME with the CON Applicant's Population Determination Method to determine the estimated population, as follows:

A. Utilize all of the population for zip codes entirely within the fifteen (15)-mile radius for LTC beds or geographic service area for hospitals and major medical equipment;

B. Reference a state highway map (or a map of greater detail) to verify population centers (see Bureau of Health Data Analysis information) within each zip code overlapped by the fifteen (15)-mile radius or geographic service area;

C. Categorize population centers as either "in" or "out" of the fifteen (15)-mile radius or geographic service area and remove the population data from each affected zip code categorized as "out";

D. Estimate, to the nearest ten percent (10%), the portion of the zip code area that is within the fifteen (15)-mile radius or geographic service area by "eyeballing" the portion of the area in the radius (if less than five percent (5%), exclude the entire zip code);

E. Multiply the remaining zip code population (total population less the population centers) by the percentage determined in (4)(C)2.D. (due to numerous complexities, population centers will not be utilized to adjust overlapped zip code populations in Jackson, St. Louis, and St. Charles counties or St. Louis City; instead, the total population within the zip code will be considered uniform and multiplied by the percentage determined in (4)(C)2.D.);

F. Add back the population center(s) "inside" the radius or region for zip codes overlapped; and

G. The sum of the estimated zip codes, plus those entirely within the radius, will equal the total population within the fifteen (15)-mile radius or geographic service area.

3. Provide other statistics, such as studies, patient origin or discharge data, Hospital Industry Data Institute's information, or consultants' reports, to document the size and validity of any proposed user-defined "geographic service area";

(6) The most current version of Forms MO 580-2501, MO 580-2502, MO 580-2503, MO 580-2504, MO 580-2505, MO 580-1861, MO 580-1869 and MO 580-1863 may be obtained by mailing a written request to the Certificate of Need Program (CONP), 915G Leslie Boulevard, Jefferson City, MO 65101, or in person at the CONP Office, or, if technically feasible, by downloading a copy of the forms from the CONP website at *[www.dhss.state.mo.us/con]* **www.dhss.mo.gov/con**.

AUTHORITY: section 197.320, RSMo 2000. Emergency rule filed Aug. 29, 1997, effective Sept. 8, 1997, expired March 6, 1998. Original rule filed Aug. 29, 1997, effective March 30, 1998. For intervening history, please consult the ***Code of State Regulations****. Emergency amendment filed June 8, 2005, effective July 1, 2005, expires Dec. 30, 2005. A proposed amendment covering this same material is published in this issue of ths* ***Missouri Register****.*