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**Rules of**  
**Department of Social Services**  
**Division 70—MO HealthNet Division**  
**Chapter 10—Nursing Home Program**

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**Title 13—DEPARTMENT OF  
SOCIAL SERVICES**

**Division 70—MO HealthNet Division  
Chapter 10—Nursing Home Program**

**13 CSR 70-10.005 Reasonable Cost-Related Reimbursement Plan for Long-Term Care**

*PURPOSE: This rule establishes a payment plan for nursing home care required by the Code of Federal Regulations (42 CFR 447.273–447.316). The plan describes cost principles to be followed by Title XIX nursing home providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing of the cost reports.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law. The forms mentioned in this rule follow 13 CSR 70-10.010.*

(1) Objectives.

(A) Uniform Plan. The provisions embodied in this rule define a system of reasonable cost-related reimbursement for long-term care (LTC) facilities participating in the Missouri Title XIX Medical Assistance Program that treats all providers of nursing care and services on a uniform basis.

(B) Adequacy of Reimbursement. Consistent with efficiency, economy and quality of care, the plan is to accomplish the purpose of adequate and reasonable reimbursement for services rendered to persons eligible for medical assistance under the Missouri Title XIX program.

(C) Improvement of Expenditure Forecasting. Capability of Title XIX management to forecast expenditures for LTC will be improved.

(2) Scope.

(A) Participating Providers. Reasonable cost-related reimbursement for LTC and services is applicable to those facilities with a valid participation agreement in effect on or after July 1, 1976, with the Missouri Department of Social Services. Areas of a facility certified to participate in the Title

XIX program by the Department of Social Services or other certifying authority approved by the Department of Social Services and the Department of Health, Education and Welfare (HEW) are covered within this rule. The provisions of this rule shall become effective January 1, 1980; however, year-end cost reports for fiscal years beginning prior to January 1, 1980, shall be prepared in accordance with the prior plan except in those areas where additional covered services have been added by this plan. These additional services shall be handled in a separate line item in the cost report. The provisions contained in this rule shall not have any retroactive effect on the cost reports or determination of any retrospective payment for fiscal years beginning prior to May 11, 1975.

(B) Allowable Costs. Each provider's total allowable costs (TACs) will be determined by the Department of Social Services from cost reports submitted on a fiscal-year basis. The fiscal year, which will be each provider's fiscal year, should coincide with the tax year used by the provider in submitting federal income tax reports.

(C) Eligible Recipients. This plan applies only to allowable costs incurred by eligible facilities for eligible recipients certified to medically require long-term, skilled, intermediate care or care for the mentally retarded, or a combination of these.

(3) Changes to Plan. Changes to the plan may be made by the Department of Social Services. Representatives of participating facilities will have an opportunity to make recommendations. All these changes will be subject to approval by the secretary of HEW and in accordance with sections 536.021 and 536.025, RSMo.

(4) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year (see subsection (2)(B) of this rule). An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.

2. Unless adequate documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost report: authenticated copies of all leases related to the activities of the facility, all management contracts, all contracts with

consultants, federal and state income tax returns for the fiscal year and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. Following the ninety (90)-day period, interim payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the interim payments that were withheld will be released.

5. If requested in writing, a reasonable extension of the filing date may be granted for good cause shown.

6. The termination by a provider of participation in the program or a change of ownership requires that the provider submit a cost report for the period ending with the date of termination or change. The cost report is due within forty-five (45) days of the date of termination or change. If requested in writing, a reasonable extension of the filing date may be granted for good cause shown.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report, whether annual or interim, must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of this authorization): for an incorporated body, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or a sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider(s):

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by \_\_\_\_\_

(Provider name(s) and number(s))

for the cost report period beginning \_\_\_\_\_, 19\_\_ and ending \_\_\_\_\_, and that to the best of my knowledge and belief, it is true, correct, and complete statement prepared



from the books and records of the provider(s) in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)

(C) Interim Reports.

1. From the beginning of its fiscal year, a provider, at its election, may submit cumulative quarterly cost reports. Insurance premiums, property taxes, professional fees and similar items shall be prorated in this report in order to avoid any distortion of allowable costs.

2. An interim cost report may be submitted for consideration whenever a participating LTC facility changes the level-of-care it has been certified to provide.

3. Whenever additional beds are added, licensed and certified to an existing facility, the facility may file an interim cost report.

(D) Adequacy of Records.

1. The records and accounting procedures of a provider must be adequate to substantiate purposes of review and audit as may be necessary in accordance with this plan.

2. At all reasonable times, the provider shall make available to the department and its duly authorized agent, including federal agents from HEW, records as are necessary to permit review and audit of the provider's cost reports. Failure to do so may lead to the penalty stated in paragraph (4)(A)4. of this rule.

3. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(5) Principles of Reasonable Cost-Related Reimbursement, Allowable Costs.

(A) General Provisions.

1. Nursing facilities participating in the Missouri Medicaid program which provide skilled or intermediate care, or intermediate care facility/mentally retarded (ICF/MR) care, or a combination of these, shall be reimbursed based upon the allowable costs of the individual nursing facility. These costs must be related to ordinary and necessary care for the level-of-care actually provided.

2. In addition to reimbursement of allowable costs, a proprietary provider shall be paid a reasonable return on owner's net equity (see section (14)).

3. Allowable costs means those costs of the provider which are allowable for allocation to the Medicaid program based upon the principles established in this rule.

4. The allowability of costs not addressed specifically in this rule will be

determined by the director, Department of Social Services, in a manner as to assure uniform application to all providers. This determination may be based upon criteria such as the Medicare Provider Reimbursement Manual (HIM-15).

5. Provider means a nursing home, or other facility as may be designated by the Department of Social Services, duly licensed and certified to participate in the Title XIX program by appropriate state agencies to furnish nursing and other care to individuals who by reason of illness, physical infirmities or advanced age are unable to care for themselves.

6. Payments to providers shall be based upon an individual accounting of the allowable costs of operation of each provider. The Department of Social Services shall have authority to require uniform accounting and reporting procedures as it deems necessary. As a minimum, standardized definitions, accounting, statistical and reporting procedures as well as expense classifications are to be in accordance with widely accepted understanding and use in health care institutions.

7. A participating nursing home is a provider which has entered into an agreement with the Department of Social Services to accept payments based upon the principles of reimbursement described in this rule and not charge the eligible recipient or any other person for covered items and services except in personal items.

8. A reasonable cost in each related cost area will be determined by the director of the Department of Social Services pursuant to section 208.152, RSMo. At his/her option, the director may follow guidelines set forth in the Medicare and Medicaid Provider Manual (HIM-15, Section 904), "Criteria for Determining Reasonable Compensation General," as applicable to the operation of the program by Missouri.

(B) Compensation of Owners.

1. Regardless of whether the provider is a corporation, partnership, proprietorship or otherwise, a reasonable allowance of compensation of services of owners shall be an allowable cost, provided the services are actually performed in a necessary function.

2. Compensation shall mean the total benefit received by the owner for the services s/he renders to the facility including: direct payments for managerial, administrative, professional and other services; amount paid by the provider for the personal benefit of the owner; the cost of assets and services which the owner receives from the provider; deferred compensation; and additional amounts determined to be the reasonable value of the services rendered by sole propri-

etors or partners and not paid by any method enumerated in this section.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable services and responsibilities in comparable institutions, or it may be determined by other appropriate means such as the Medicare and Medicaid Provider Reimbursement Manual (HIM-15).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(C) Covered Services and Supplies.

1. Skilled nursing facility (SNF) and ICF services and supplies covered by this plan are those found in 42 CFR 442.100—442.516 which include, among other services, the regular room, dietary and nursing services or any other services that are required for standards of participation or certification; also included are minor medical and surgical supplies and the use of equipment and facilities. Services set out in subparagraphs (5)(C)1.G. and H. of this rule shall be covered services effective January 1, 1980. These items include, but are not limited to, the following:

A. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray services and enemas;

B. Items which are furnished routinely and relatively uniformly to all recipients, for example, gowns, water pitchers, basins and bed pans;

C. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities such as alcohol, applicators, cotton balls, and bandaids, antacids, aspirins (and other non-legend drugs ordinarily kept on hand), suppositories and tongue depressors;

D. Items which are utilized by individual recipients, but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, nondepreciable medical equipment;

E. Additional items as specified in the appendix to this plan when provided to the patient;

F. Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet including dietary supplements written as a prescription item by a physician;



G. All laundry services including personal laundry; and

H. All general personal care services which are furnished routinely and relatively uniformly to all recipients for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service.

(I) All consultive services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report, as specified in paragraph (4)(A)2. of this rule. Failure to do so will result in the penalties specified in paragraph (4)(A)4. of this rule.

(II) All services and supplies not included in allowable costs shall be treated as services and supplies not covered by the Medicaid program.

(III) The provider may collect from recipients, their relatives or from the recipient's personal needs fund only charges for personal items, noncovered services and supplies and prescription drugs not on the formulary.

(D) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business, including items that are used in a normal standby or emergency capacity, is an allowable cost.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the program basis of the asset and prorated over the estimated useful life of the asset using the straight line method of depreciation from the date initially put into service.

3. The program basis of assets shall be lower of the book value of the provider, fair market value at the time of acquisition or the recognized Internal Revenue Service (IRS) tax basis. Donated assets will be allowed basis to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a nursing home facility and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the nursing home facility in ratio to Medicaid recipients.

4. Allowable methods of depreciation shall be limited to the straight line method.

The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be the same as the provider claims for IRS purposes. Component part depreciation is optional and allowable under this plan.

5. Historical cost is the cost incurred by the provider in acquiring the asset and to prepare it for use except as provided for in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees, consulting fees and related legal fees. Where a provider has elected for federal income tax purposes to expense certain items, such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off these costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this plan, any asset costing less than three hundred dollars (\$300) or having a useful life of one (1) year or less may be expensed and not capitalized at the option of the provider.

6. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of the undepreciated cost basis of the traded asset plus the cash paid and subsection (10)(A) shall not apply.

7. For the purpose of determining allowance for depreciation under the Medicaid program, the cost basis of a facility purchased as an ongoing operation after July 1, 1976, shall be the price paid by the purchaser or the appraised value, whichever is lower. If the purchaser cannot demonstrate that the sale was a bona fide sale, the cost basis of the seller shall be determined on the basis of the value reported to IRS for the year immediately preceding the sale.

8. Subject to the principles enumerated in this subsection, the cost basis usable for depreciation of the facility to the purchaser shall be the lower of the purchaser's book value for the facility, the recognized IRS tax basis or the depreciable cost as determined in paragraph (5)(D)7.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred thousand dollars (\$100,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures are disallowed by the provisions of federal Social Security Act,

Section 1122(B), Social Security Amendments of 1972, Sections 221(B) and (D) or for failure to comply with any other federal act that promulgates a limitation on reimbursement for capital expenditures under federal or state legislation.

(E) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short-term. This is usually for purposes as working capital for normal operating expense. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and equipment and capital improvements. Generally, loans for capital purposes are long-term loans.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost under the Medicaid program, interest (including finance charges, prepaid costs and discount) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claimed, and necessary and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary, as used in these rules, means that the interest be incurred on a loan made to satisfy a financial need of the provider and for a purpose reasonably related to recipient care. Loans which result in excess of funds or investments would not be considered necessary.

6. Proper, as used in these rules, means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.

7. Interest on loans to providers by proprietors and general partners shall not be an allowable cost because these loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. Interest on loans to providers by limited partners or minority stockholders shall be an allowable cost at a rate not in excess of a reasonable rate. If a provider operated by members of a religious



order borrows from the order, interest paid to the order shall be an allowable cost.

8. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

9. A provider shall amortize finance charges, prepaid interest or discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance where the time period is in excess of twelve (12) months.

10. Usual and customary costs incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

11. Usual and customary costs include, but are not limited to, lender's finance charges or fees, title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

12. Loan costs shall be allowable costs only to the extent that they meet the criteria established in this rule for the allowance of interest expense in general.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred thousand dollars (\$100,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost if those capital expenditures are disallowed by the secretary of Health and Human Services (HHS) for failure to comply with the provisions of federal Social Security Act, Section 1122(B), Social Security Amendments of 1972, Sections 221(B) and (D), or for failure to comply with any other federal or state requirement that promulgates a limitation on reimbursement for capital expenditures.

(F) Rental Costs.

1. Rental costs of land, buildings, furnishings and equipment are allowable costs provided that the rented items are reasonable, necessary and not in essence a purchase of those assets.

2. Necessary rental items are those which are pertinent to the operation and sound conduct of the provider, including items that are used in a normal standby or emergency capacity.

3. Reasonable rental amounts are the lesser of those which are actually paid or those that would be paid to an unrelated party for use of the same property.

4. Determination of reasonableness in individual cases may be established by affidavits of competent, impartial experts who are familiar with the current rentals in the community.

5. The test of reasonableness shall take into account the agreement between the

owner and the tenant regarding the payment of related property costs.

6. In the case of rental costs paid to individuals or organizations related to the provider by common ownership or control (or to the lessors or an ongoing facility), the rental amounts shall not exceed the lesser of actual or reasonable costs to constitute allowable costs (see paragraph (5)(F)3.).

7. Related to the provider, common ownership and control have the same meaning as defined in paragraphs (5)(N)2. and 3.

8. Lessor of an ongoing facility means any owner of rented property who had used the property to participate in the Medicaid program on or after January 1, 1976.

9. In the case of rental costs paid to the lessor of an ongoing facility, the rental amounts must not be in excess of reasonable rental costs (see paragraph (5)(F)3.).

(G) Taxes.

1. Taxes levied on or incurred by a provider shall be allowable costs with the exception of the following items:

A. Federal, state or local income and excess profit taxes including any penalties paid them;

B. Taxes, in connection with financing, refinancing or refunding operations such as taxes on the issuance of bonds, property transfer, issuance or transfer of stocks. Generally, these costs are either amortized over the life of the securities or depreciated over the life of the asset. They are not, however, recognized as a tax expense;

C. Taxes from which exemptions are available to the provider;

D. Special assessments on land which represent capital improvements such as sewers, water and pavements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid in annual installments;

E. Taxes on property which is not a part of the operation and sound conduct of the provider nor used in a normal standby or emergency capacity;

F. Taxes, such as sales taxes, which are levied against the recipient and collected and remitted by the provider; and

G. Self-employment Federal Insurance Contribution Act (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, to the extent these taxes exceed the amount which would have been paid by the provider on the allowable compensation of these persons had the provider organization been an incorporated rather than unincorporated entity.

(H) Issuance of Revenue Bonds and Tax Levies by District and County Facilities. Those nursing home districts and county

facilities whose funding is through the issuance of revenue bonds, in accordance with sections 198.312 and 205.371—205.375, RSMo will be granted as an allowable cost that interest which is paid per the revenue bonds; depreciation on the plant and equipment of these facilities shall also be an allowable cost. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset, except to the extent that the funds are used for the actual operation of the facility.

(I) Value of Services of Employees.

1. The value of services performed by employees in the facility shall be included in allowable costs to the extent actually compensated, either to the employee directly or to the supplying organization.

2. Services rendered *gratis* by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations, shall not be included in allowable costs, as these services traditionally have been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost provided that the services are not of a religious nature. An example of an allowable cost under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(J) Fringe Benefits.

1. Life insurance.

A. Types of insurance which are not considered an allowable cost—premiums related to insurance on the lives of officers and key employees are not allowable costs under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where, insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit



against the loan balance. In this case, the provider is an indirect beneficiary. Insurance of this type is referred to as credit-life insurance.

B. Types of insurance which are considered an allowable cost where—

(I) Credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) The relative(s) or estate of the employee is the beneficiary. This type of insurance is considered to be compensation to the employee as a fringe benefit and is an allowable cost to the extent that the amount of coverage is reasonable.

#### 2. Retirement plans.

A. Contributions to retirement plans for the benefit of employees, including owner employees of the provider, shall be allowable costs provided these plans meet the qualifications established in Section 401 of the *Internal Revenue Code* of 1954, as amended in the requirements for Title XVIII. These requirements state that—“A trust created or organized in the United States and forming parts of a stock bonus, pension or profit-sharing plan of an employer for the exclusive benefits of his/her employees or their beneficiaries shall constitute a qualified trust under this section if the contributions or the benefits provided under the plan do not discriminate in favor of employees who are—1) officers; 2) shareholders; or 3) highly compensated.” Interest income from funded pension or retirement plans shall be excluded from consideration in determining the allowable costs.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due or as anticipated and offset to expenses on the cost report form.

#### 3. Deferred compensation plans.

A. Contributions for the benefit of employees, including owner employees under deferred compensation plans, shall be allowable costs when and to the extent that these costs are actually incurred and met by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost only when paid to the participating employee and only to the extent considered reasonable.

B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually incurred and met by the provider.

C. Amounts funded to deferred compensation plans together with associated

income shall be recaptured if not actually paid when due or as anticipated and offset to expenses on the cost report form.

#### (K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care of administration of the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is allowable only when specifically authorized in advance by the department.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

#### (L) Organizational Costs.

1. Organizational costs may be included in allowable costs on an amortized basis.

2. Organizational costs include, but are not limited to, the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stock holders; and fees paid to states for incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off these costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to his/her entry into the program and properly has capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance, the unamortized portion of organizational costs is allowable under the program and shall be amortized over the remaining part of the sixty (60)-month period.

(M) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing the provider services shall be allowable costs. These costs must be common and accepted occurrences in the field of the activity of the provider.

#### (N) Costs of Related Organizations.

1. Purchase from related organization(s). Costs applicable to services, facilities and supplies furnished to a provider by organization(s) related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the prices of comparable services, facili-

ties or supplies purchased elsewhere. The provider shall be required to identify the related organization(s) and costs to the related organization(s) in the uniform cost report(s). For the purpose of this section, common ownership and control will be determined by paragraphs (5)(N)2. and 3. of this rule.

2. Related to the provider means the following:

A. With respect to a partnership, each partner;

B. With respect to a limited partnership, the general partner and each limited partner with an interest of five percent (5%) or more in the limited partnership;

C. With respect to a corporation, each person who owns, holds or has the power to vote five percent (5%) or more of any class of securities issued by the corporation and each officer and director; and

D. With respect to a natural person, any parent, child, sibling or spouse of that person.

3. For the purposes of this section only, owner of a facility refers to any person who owns an interest of five percent (5%) or more in the following:

A. The land on which any facility is located;

B. The structure(s) in which any facility is located;

C. Any mortgage, contract for deed or other obligation secured in whole or part by the land or structure in or on which any facility is located; or

D. Any lease or sublease of the land or structure in or on which a facility is located. Owner does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly or through a subsidiary operates a facility.

(O) Utilization Review. Incurred cost for the performance of required utilization review for SNF, ICF, ICF/MR or SNF/ICF combination is an allowable cost. These expenditures must be for the purpose of providing utilization review on behalf of Title XIX recipients. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of recipient days recorded for each program during the reporting period.

#### (6) Upper Limits.

(A) In no event may the total reimbursement of a provider exceed the lesser of—

1. The current customary charges by the facility to the general public for the same services rendered to the Medicaid recipients



except in the case of public facilities rendering services at a nominal charge; these charges will be determined by the standard set forth in the *Medicare Provider Reimbursement Manual* (HIM-15), Part I, Section 2600;

2. The Title XVIII rates applicable; and

3. One hundred twenty-five percent (125%) of the weighted mean rate paid for each level-of-care group as follows: SNF, ICF, ICF/MR and SNF/ICF combination.

(B) The determination of weighted mean per-diem rates by level-of-care shall be determined and updated quarterly using reimbursement rates in effect the first day of that quarter.

(C) Providers shall be considered as similar facilities when classed by the following levels of care: ICF/MR or SNF, ICF, SNF/ICF combination.

(D) All costs in excess of the ceiling imposed shall not be carried forward.

#### (7) Minimum Utilization.

(A) In the event that the occupancy utilization of a provider in a cost-reporting period falls below ninety percent (90%) of its certified bed capacity, appropriate adjustments shall be made to the allowable costs of the provider. Fixed costs will be calculated as if the provider experienced ninety percent (90%) utilization. The fixed costs are laundry, housekeeping, administrative and general costs. Variable costs will be calculated at actual utilization. The variable costs are nursing, dietary and ancillary costs.

(B) In the event a provider's total reimbursement is reduced below allowable costs due to the limitation in subsection (7)(A), the unreimbursed allowable cost shall be subject to subsection (7)(C) and, if no waiver is granted, the retroactive adjustment shall be the lower of the actual cost or cost established under the provisions of subsection (7)(A).

(C) Subsections (7)(A) and (B) shall be waived for newly constructed facilities, new additions, or both, until an occupancy level of ninety percent (90%) is reached, but that waiver shall not exceed twelve (12) months from the date of licensure. A second waiver may be granted for an additional twelve (12)-month period. Subsections (7)(A) and (B) also will be waived for any facility which is closed completely for six (6) months or more and whose residents are removed, if and when this facility reopens.

#### (8) Nonreimbursable Costs.

(A) Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included in allowable costs.

(B) Those services that are specifically listed as provided in section 208.152, RSMo are attributable to Medicare and Medicaid and should be billed to those agencies.

(C) Any costs incurred that are related to fund drives are not reimbursable.

(D) Costs incurred for research purposes shall not be included as allowable costs.

(E) The cost of services provided under contract or subcontract under the Title XX program is specifically excluded as allowable costs.

#### (9) Other Revenues.

(A) Other revenues including, but not limited to those listed as follows, will be deducted from the total allowable cost, if included in gross revenue: income from telephone service; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts, purchase rebates and refunds; recovery on insured loss; parking lot revenues; hospital room reservation charges; vendor machine commission; sales from drugs to other than recipients; sales from medical and surgical supplies to other than recipients; and room reservation charges in excess of two (2) days per quarter.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided the interest is applied to the replacement of the asset being depreciated. Interest income other than from funded depreciation in excess of interest expense will not be used to offset other allowable costs.

(C) Cost centers or operations specified by the provider as subsection (10)(D) shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

#### (D) Restricted and Unrestricted Funds.

1. Restricted funds, as used in this rule, mean those funds, cash or otherwise, and including grants, gifts, taxes and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to restrict restricted funds designated by the donor for paying operating costs, these funds will not be offset from total allowable expenses.

2. Unrestricted funds, as used in this rule, mean those funds, cash or otherwise, and including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as

to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

3. Transferred funds, as used in this rule, are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local governmental provider. The transfer can be state-to-state, state-to-local or local-to-local providers. These funds are not considered a grant or gift for reimbursement purposes, so have no effect on the provider's allowable cost under this plan.

#### (10) Gains and Losses on Sales of Fixed Assets.

(A) Gains and losses on the sale or other disposition of buildings, furniture and equipment of a provider shall be taken into account in the determination of allowable costs only to the extent that the following provisions are applicable.

(B) There shall be a recapture of any subsection (10)(A) gain or loss according to the following ratio:

1. The numerator shall be the number of years during the asset life after July 1, 1976, that the provider has been reimbursed for all allowable costs by the Department of Social Services for Title XIX services. For the purposes stated here, the year in which the asset was purchased shall be included but the year in which the asset disposition is made will not be considered;

2. The denominator shall be the number of years the asset was owned and used in the operation of Title XIX facility; and

3. The ratio shall not exceed one hundred percent (100%).

(C) There shall be no recapture of any subsection (10)(A) gain or loss, in accordance with subsection (10)(B), unless subsection (10)(A) gain or loss, exceeds one thousand dollars (\$1000).

(D) The provider may designate specific assets or operations with the submission of each cost report that are not to be considered as relating to the nursing facility operation. The gains or losses from the sales of these assets or operations shall not be subject to subsections (10)(A)—(C).

(E) The provisions of subsections (10)(A)—(C) shall not apply to the dispositions of whole nursing facilities or similar changes of ownership.

#### (11) Apportionment of Costs to Medicaid Recipients.



(A) A provider's allowable costs shall be apportioned between Medicaid program recipients and other patients so that the share borne by the Medicaid program is based upon actual services received by program recipients.

(B) To accomplish this apportionment, the ratio of recipient's charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for program recipients determined on the basis of a separate average cost per diem for general routine care areas or, at the option of the provider, on the basis of the overall routine care area.

(C) So that its charges may be allowable for use in apportioning costs under the program, each provider should have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonably and consistently related to the cost of providing these services.

(D) Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

(E) A patient day of care is that period of service rendered a patient between the census taking hours on two (2) successive days, the day of discharge being counted only when the patient was admitted that same day. A census log shall be maintained in the facility for documentation purposes.

(F) Nursing facilities that provide skilled or intermediate nursing care, or both, to Medicaid recipients may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share common services and facilities as management services, dietary, housekeeping, building maintenance and laundry.

(G) Reimbursement is to be limited to the lower of the level-of-care required by the recipient or the level-of-care provided in the distinct part to which the recipient is assigned if admitted in accordance with 42 CFR 456.600-456.614.

(H) In no case may a provider's allowable costs allocated to the Medicaid program include the cost of furnishing services to persons not covered under the Medicaid program.

#### (12) Accounting Basis.

(A) The cost report submitted must be based on the accrual basis of accounting.

(B) Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods provided appropriate treatment of capital expenditures is made.

#### (13) Audits.

(A) Cost reports submitted shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

(B) If the provider has included the cost of a certified audit of the facility as a covered expense to this plan, a copy of that audit report and accompanying management letter shall be submitted without deletions.

(C) The annual cost report for the fiscal year of the provider shall be subject to audit by the Department of Social Services or their contracted agents. An audit guide will be prepared specifying the audit standards to be employed by the department.

(D) The department will conduct a desk review of all cost reports within four (4) months after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

(E) No less than one-third (1/3) of the participating LTC facilities are to be audited each year over a three (3)-year period starting with the close of the cost reporting years beginning on or after January 1, 1977. These audits will be scheduled in a manner as to ensure that, at the close of this three (3)-year period, each participating LTC facility will have been audited.

(F) The department shall retain the annual cost report and any working paper relating to audits of the cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

(G) In accordance with the provisions of 42 CFR 447.295, a report of each on-site audit shall be submitted to the director of the Department of Social Services.

(H) In accordance with the provisions of 42 CFR 447.293, on-site audits will be performed each year after the initial three (3)-year period in at least fifteen percent (15%) of the participating facilities. At least five percent (5%) of the participating facilities shall be selected on a random basis and the remainder on the basis of exceptional profiles.

(I) Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%), an annual Title XIX payment of two hundred

thousand dollars (\$200,000) or more, or both, shall be required for at least the first two (2) fiscal years of participation in the plan to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. The Department of Social Services will accept a qualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the nursing home facility.

#### (14) Return on Equity.

(A) A return on a provider's net equity shall be paid as a part of the interim per-diem rate in addition to allowable costs.

(B) The amount of return on a provider's net equity shall initially be twelve percent (12%) for the state's fiscal year period 1976-1977; a new rate of return shall be established by the Department of Social Services each year thereafter prior to October 1 of that year. This rate shall be published yearly and, upon publication, shall be incorporated into this plan.

(C) For the purposes of this paragraph, owner's net equity is defined according to the *Medicare Provider Reimbursement Manual* (HIM-15), Section 1202.

(D) The return on owner's net equity shall be payable only to proprietary providers.

(E) A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program days of care to total recipient days of care during the cost reporting period. For the purpose of this calculation, total recipient days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy rate during the cost year.

(15) Allowance for Known Cost Changes. A provider, at its election, may include with any regularly filed cost report, as an integral part of the report, a statement of known cost changes which reasonably can be anticipated to change the allowable costs of the subsequent cost-reporting period and which fall within guidelines as established by the department. Based upon this information, the provider may obtain an increase in its interim rate to cover the increases, provided adequate documentation is submitted with the report regarding the nature and amount of cost increases and their anticipated effect upon allowable costs in the subsequent reporting period.





(16) Inflationary Adjustments. Inflationary adjustments will be considered in calculating the interim per-diem rate. They will be based upon the past fiscal year and will be adjusted according to an index such as the *Composite Consumer Price Index (CPI)*. Rental, interest, depreciation expenses and property taxes will be excluded from the adjustments.

(17) Interim Rate.

(A) Each participating provider shall be assigned an interim per-diem rate for reimbursement under the Medicaid program which will be based principally upon the cost report of the facility for the preceding reporting period. Interim rates shall be established based upon the date in the cost report, adjusted as described in this rule and subject to further adjustment later by reason of audit changes to the cost report.

(B) A provider's interim rate for a given period shall take into account its past allowable costs and return on owner's net equity, all as most recently determined, together with an allowance for known cost increases.

(C) Upon initial entry into the Medicaid program after July 1, 1976, a provider not having had a full year of prior operation may submit budgetary projections of allowable costs to the department for the purpose of establishing an initial Medicaid interim rate. These budgetary projections shall be taken into consideration and included in the initial interim per-diem rate to the extent they do not exceed one hundred twenty-five percent (125%) of the weighted mean rate as determined by section (6). A new facility must operate at the initial rate for at least six (6) months.

(D) The budgetary projections shall be based upon a minimum occupancy utilization of ninety percent (90%) pursuant to the principles established in section (7).

(E) In the case of a change of ownership of an ongoing facility already participating in the Medicaid program, the rates in effect at the time of the change in ownership shall continue until new interim cost reports are submitted by the new owner in accordance with paragraph (4)(C)1. or 2.

(F) Approved interim rates shall become effective on or before the first day of the third month following the filing of any cost report as described in this rule.

(G) A written notification indicating the SNF, ICF, ICF/MR and SNF/ICF combination per-diem rates respectively will be transmitted to the facility upon approval by the director, Department of Social Services or his/her designee.

(H) In the event either party determines that a significant error or omission has been

made in the determination of the per-diem rate, this will be reported within thirty (30) days. Upon proper analysis of the problem, the Department of Social Services will be authorized to make adjustments consistent with the principles set forth in this rule and shall notify the provider in writing of its decision. In the event the decision is not acceptable, the provider has the right to appeal within sixty (60) days as provided under this plan, section (20).

(18) Retroactive Adjustments. Initial retroactive adjustments for each year payable to the provider and made in accordance with this plan shall be paid as soon as practicable within one hundred eighty (180) days after receipt of the provider's fiscal year cost report.

(19) Amounts Due the Department of Social Services for a Provider

(A) When there is an amount due the Department of Social Services from a provider, the single state agency shall notify the provider or the provider's representative of the amount of the overpayment. When a provider receives notice of an overpayment and the amount due is in excess of one thousand dollars (\$1000), the provider, within twenty (20) days of the notice, shall submit a plan for repayment to the single state agency which shall not exceed six (6) months in duration and request that the plan be adopted and adhered to by the single state agency in collecting the overpayment. If an alternative repayment plan is received timely from a provider, the single state agency shall consider the proposal, together with all the facts and circumstances of the case, and reject, accept or offer to accept a modified version of the provider's plan for repayment. The single state agency shall notify the provider of its decision within fifteen (15) days after the proposal is received. If no alternative plan for repayment is agreed upon within forty-five (45) days after the provider received notice of the overpayment, the withholding of payments to the provider shall commence as if no alternative plan for repayment had been submitted. Overpayments of one thousand dollars (\$1000) or less shall be repaid within forty-five (45) days.

(B) If a plan for repayment of amounts due the Department of Social Services from a provider is breached, discontinued or otherwise violated by a provider, the single state agency, immediately upon the next payment to the provider, shall begin to withhold payments or portions of payments until the entire amount due has been collected.

(C) If a provider fails or refuses to comply with the provisions of this rule, the single

state agency, at its discretion, may withhold funds from amounts due the provider in amounts as to guarantee full recovery of an overpayment over a period of time as the single state agency deems warranted under the circumstances.

(D) Repayment or an agreement to repay amounts due the Department of Social Services by a provider shall not prevent the imposition of any sanction by the single state agency upon the provider.

(E) The Department of Social Services shall account to HHS for the amounts on Form HCFA-64 (see 10 CSR 70-10.010) owed by providers no later than the second quarter following the quarter in which the overpayment was determined in accordance with principles of the plan.

(20) Appeals. Unresolved provider disputes involving an amount in excess of five hundred dollars (\$500) may be appealed to the Administrative Hearing Commission under the provisions of sections 161.274 and 208.156, RSMo and the corresponding rules established by the commission.

**APPENDIX  
Routine Covered Medical Supplies  
and Services**

- ABD Pads
- A & D Ointment
- Adhesive Tape
- Air Mattresses
- Air P.R. Mattresses
- Airway Oral
- Alcohol
- Alcohol Plasters
- Alcohol Sponges
- Antacid Suspensions
- Antipruritic Oil
- Applicators, Cotton-Tipped
- Applicators, Swab-Eez
- Aquamatic K Pads (water-heated pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages Elastic or Cohesive
- Bandaids
- Basins
- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpan, Fracture
- Bedpan, Regular
- Bedside, Tissues
- Benzoin
- Bibs
- Bottle, Specimen
- Canes



Cannula—Nasal  
 Cascara (1 oz.)  
 Catheter, Indwelling  
 Catheter Plugs  
 Catheter Tray  
 Catheters (any size)  
 Colostomy Bags  
 Composite Pads  
 Cotton Balls  
 Crutches  
 Customized Crutches, Canes and  
     Wheelchairs  
 Decubitus Ulcer Pads  
 Deodorants  
 Disposable Underpads  
 Donuts  
 Douche Bags  
 Drain Tubing  
 Drainage Bags  
 Drainage Sets  
 Drainage Tubes  
 Dressing Tray  
 Dressings (all)  
 Drugs, Nonlegend  
 Drugs, Stock (excluding Insulin)  
 Enema Can  
 Enema—Fleets  
 Enema—Retention  
 Enema Soap  
 Enema Supplies  
 Enema Unit  
 Enemas  
 Equipment and Supplies for Diabetic Urine  
     Testing  
 Eye Pads  
 Feeding Tubes  
 Female Urinal  
 Flotation Mattress or Biowave Mattress  
 Flotation Pads, Turning Frames, or Both  
 Folding Foot Cradle  
 Gastric Feeding Unit  
 Gauze Sponges  
 Gloves, Unsterile and Sterile  
 Gowns, Hospital  
 Green Soap  
 Hand-Feeding  
 Heat Cradle  
 Heating Pads  
 Heel Protector  
 Hot Pack Machine  
 Ice Bags  
 Incontinency Care  
 Incontinency Pads and Pants  
 Infusion Arm Boards  
 Inhalation Therapy Supplies  
     Aerosol Inhalators, Self-Contained  
     Aerosol (other types)  
     Nasal Catheter Insertion and Tube  
     Nebulizer and Replacement Kit  
     Steam Vaporizer  
 Intermittent Positive Pressure Breathing  
     Machines (IPPB)

Invalid Ring  
 Irrigation Bulbs  
 Irrigation Trays  
 I.V. Trays  
 Jelly—Lubricating  
 Kaolin and Pectin Solution  
 Linens, Extra  
 Lotion, Soap and Oil  
 Male Urinal  
 Massages (by nurses)  
 Medical Social Services  
 Medicine Cups  
 Medicine Dropper  
 Merthiolate Aerosol  
 Milk of Magnesia  
 Mineral Oil  
 Mouthwashes  
 Nasal Cannula  
 Nasal Catheter  
 Nasal Gastric Tubes  
 Nasal Tub Feeding  
 Needles (hypodermic, scalp, vein)  
 Needles (various sizes)  
 Nonallergic Tape  
 Nursing Services (all) regardless of level,  
     including the administration of oxygen  
     and restorative nursing care  
 Nursing Supplies and Dressings (other than  
     items of personal comfort or cosmetics)  
 Ointment (nonprescription, skin)  
 Overhead Trapeze Equipment  
 Oxygen  
 Oxygen Equipment (such as IPPB machines  
     and oxygen tents)  
 Pads  
 Peroxide  
 Pharmaceuticals, Nonprescription  
 Pitcher  
 Plastic Bib  
 Pumps (aspiration and suction)  
 Restraints  
 Room and Board  
 Sand Bags  
 Scalpel  
 Sheepskin  
 Special Diets  
 Specimen Cups  
 Sponges  
 Sterile Pads  
 Stomach Tubes  
 Suction Catheter  
 Suction Machines  
 Suction Tube  
 Suppositories—Nonlegend  
 Surgical Dressings (including sterile  
     sponges)  
 Surgical Pads  
 Surgical Tape  
 Suture Trays  
 Syringes, Disposable  
 Tape (for laboratory tests)  
 Tape (nonallergic or butterfly)

Testing Sets and Refills (S & A)  
 Tongue Depressors  
 Tracheostomy Sponges  
 Tray Service  
 Tubing—I.V. Trays, Blood Infusion Set,  
     I.V. Tubing  
 Underpads  
 Urinary Drainage Tube  
 Urinary Tube and Bottle  
 Urological Solutions  
 Walkers  
 Water Pitchers  
 Wheelchairs

*AUTHORITY: section 207.020, RSMo Supp. 1993. \* This rule was previously filed as 13 CSR 40-81.080. Original rule filed Jan. 16, 1978, effective May 11, 1978. Emergency rescission filed Dec. 7, 1979, effective Dec. 31, 1979, expired March 12, 1980. Emergency rule filed Dec. 7, 1979, effective Jan. 1, 1980, expired March 12, 1980. Rescinded and readopted: Filed Dec. 7, 1979, effective May 11, 1980. Emergency amendment filed July 23, 1981, effective Aug. 1, 1981, expired Nov. 11, 1981. Amended: Filed July 23, 1981, effective Nov. 12, 1981. Emergency amendment filed Oct. 13, 1981, effective Oct. 23, 1981, expired Jan. 13, 1982. Amended: Filed Oct. 13, 1981, effective Jan. 14, 1982.*

*\*Original authority 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993.*

### 13 CSR 70-10.010 Prospective Reimbursement Plan for Long-Term Care

*PURPOSE: This rule establishes a payment plan for long-term care required by the Code of Federal Regulations. The plan describes principles to be followed by Title XIX long-term care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate rules.



(2) Purpose. This rule establishes a methodology for determination of prospective per-diem rates for long-term care (LTC) facilities.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) program.

(B) The per-diem rates determined by this rule shall apply only to services provided on and after July 1, 1990.

(C) The effective date of this rule shall be July 1, 1990.

(D) The Medicaid program shall provide reimbursement for LTC services based solely on the individual Medicaid-eligible recipient's covered days of care (within benefit limitations) multiplied by the facility's Medicaid per-diem rate. No payments may be collected or retained in addition to the Medicaid per-diem rate for covered services. Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid per-diem rate shall be the lower of—

1. The Medicare (Title XVIII) per-diem rate, if applicable;

2. The per-diem rate as determined in accordance with section (11); or

3. The LTC ceiling (LTCC). The LTCC in effect on July 1, 1990, shall be a per-diem rate of fifty-four dollars and ninety-five cents (\$54.95). The LTCC will be increased by the amounts prescribed in paragraph (12)(A)1. effective for the dates of services and purposes specified in paragraph (12)(A)1.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A per-diem reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid program shall be assigned a provider number by the Division of Medical Services. Facilities previously certified shall retain the same provider number regardless of any change in ownership.

(H) Regardless of changes in ownership for any facility certified for participation in the Medicaid program, the division will issue allowable reimbursements to the facility identified in the current Medicaid participation agreement and will recover from that entity

liabilities, sanctions and penalties pertaining to the Medicaid program.

(I) A facility with certified and noncertified beds shall allocate allowable costs related to the provisions of LTC services in an equitable manner. The methods for allocation must be supported by adequate accounting, statistical data, or both, necessary to evaluate the allocation method and its application.

(J) Any facility which is terminated from participation in the Medicare program also shall be terminated from participation in the state's Medicaid program on the same date as the Medicare determination.

(K) No restrictions nor limitations shall be placed on a recipient's right to select providers of his/her own choice.

(L) The average Medicaid rate paid shall not exceed the average private pay rate for the same period covered by the facility's Medicaid cost report. Any amount in excess will be subject to repayment, recoupment, or both.

(4) Definitions.

(A) Allowable cost. Those costs which are allowable for allocation to the Medicaid program based upon the principles established in this rule. The allowability of costs not addressed specifically in this rule shall be determined by the Division of Medical Services. This determination may be based upon criteria such as the *Medicare Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Average private pay rate. The usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into revenue net of contractual allowances from the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with state or federal agencies such as the Veterans Administration and the Missouri Department of Mental Health.

(C) The Building Cost Calculator (formerly known as the *Dodge Construction Index*). The cost per square foot as published in *Calculator and Valuation Guide* for a convalescent/nursing home of good quality, masonry wall construction as of mid-year 1970 and adjusted by the general purpose Local Building Cost Multiplier as of the following date: 1) the date the original Certificate of Need (CON) or waiver was issued, 2) if a six (6)-month extension was granted, the date the first extension was granted, or 3) if the facility was constructed prior to October 1, 1980, the date will be October 1, 1980. The Local Building Cost Multipliers used to adjust costs shall be those established for Columbia, Kansas City and St. Louis. The multiplier to

be used in determining a facility's rate shall be the one established for the city geographically closest to the facility as determined by the straight line distance (not road miles) between the two (2) points, as determined from the latest Missouri official highway map furnished by the Missouri Highways and Transportation Department. *Calculator and Valuation Guide* is a publication of Calculator, Inc., 12251 Harbor Drive, Woodbridge, VA 22192.

(D) Change of ownership. A change in ownership, control, operation or leasehold interest by any form for any facility certified for participation in the Medicaid program at any time.

(E) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in subsection (10)(A) of this rule and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with the procedures prescribed by the division and on forms provided or prescribed, or both, by the division.

(F) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(G) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(H) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(I) Division. Unless otherwise designated, division refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(J) Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure of LTC facilities.

(K) Entity. Any natural person, all corporations, business, partnership or something that exists as a discrete unit.

(L) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(M) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing those principles.



(N) Intermediate care facility (ICF). Prior to October 1, 1990, a facility certified to provide intermediate care under the Title XIX program.

(O) LTC facility. Prior to October 1, 1990, a facility certified to provide skilled nursing services under the Title XIX program (skilled nursing facility (SNF)), or a facility certified to provide intermediate care under the Title XIX program (ICF), or a facility certified to provide skilled nursing and intermediate care under the Title XIX program (SNF/ICF). On and after October 1, 1990, a nursing facility (NF).

(P) New facility. A newly-built LTC facility for which an approved CON or applicable waiver was obtained and which was newly completed and operational on or after July 1, 1990.

(Q) Nursing facility (NF). Effective October 1, 1990, SNFs, SNF/ICFs and ICFs participating in the Medicaid program all will be subject to state and federal laws or regulations for participation as an NF.

(R) Occupancy. A facility's total actual patient days divided by the total bed days for the same period.

(S) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. Patient day includes the allowable temporary leave-of-absence days per subsection (5)(D). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(T) Provider or facility. An LTC facility with a valid Medicaid participation agreement in effect on or after July 1, 1990, with the Department of Social Services for the purpose of providing LTC services to Title XIX-eligible recipients.

(U) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity in which, through its activities, one (1) entity's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in those dealings;

2. An entity has an ownership or controlling interest in another entity and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking

firm or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in this rule, the following terms mean:

A. Indirect ownership/interest, an ownership/interest in an entity that has an ownership/interest in another entity. This term includes an ownership/interest in any entity that has an indirect ownership/interest in an entity;

B. Ownership/interest, the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest, when an entity—

(I) Has an ownership/interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership/interest equal to five percent (5%) or more in an entity. The amount of indirect ownership/interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership/interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

D. Relative, person related by blood, adoption or marriage to the fourth degree of consanguinity.

(V) Restricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which must be used only for a specific purpose designated by the donor.

(W) Skilled nursing facility (SNF). Prior to October 1, 1990, a facility certified to provide skilled nursing services under the Title XIX program.

(X) SNF/ICF combination. Prior to October 1, 1990, a facility certified to provide skilled nursing and intermediate care under the Title XIX program.

(Y) Square footage. The square footage of a facility will be determined from the records of the county assessor of the county where the facility is located. For facilities that are

exempt from property tax assessment, the square footage of the facility shall be determined from a certified statement from a licensed architect verifying the square footage of the facility in accordance with the American Institute of Architects Document D101.

(Z) Unrestricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a per-diem rate but which also are billable to the Title XVIII Medicare program must be billed to that program for facilities participating in the Title XVIII Medicare program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and supplies required by federal or state law or regulation which must be provided by LTC facilities participating in the Title XIX program;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, and the like;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days specifically must be provided for in the recipient's plan of care and physician prescribed. Periods of time during which a recipient is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of nursing services;

(F) Provision of personal hygiene and routine care services furnished routinely and relatively uniformly to all residents;

(G) All laundry services, including personal laundry;

(H) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(I) All consultative services required by federal or state law or regulation;

(J) All therapy services required by federal or state law or regulation;

(K) All routine care items, including disposables and including, but not limited to,



those items specified in Appendix A to this rule;

(L) All nursing care services and supplies, including disposables and including, but not limited to, those items specified in Appendix A to this rule;

(M) Any and all nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's per-diem rate; and

(N) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Noncovered Supplies, Items and Services. All supplies, items and services which are not either covered in a facility's per-diem rate, billable to another program in the Missouri Medical Assistance (Medicaid) program or billable to Medicare or other third-party payors. Noncovered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection and loud irrational speech. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service and therefore a Medicaid recipient or responsible party may pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid per diem unless the recipient or responsible party, in writing, specifically requests a private room prior to placement in one and acknowledges that an additional amount not payable by Medicaid will be charged for it;

(B) Supplies, items and services for which payment is made under Missouri Medical Assistance (Medicaid) program directly to a provider(s) other than providers of the LTC services; and

(C) Supplies, items and services provided nonroutinely to residents for personal comfort or convenience.

(7) Allowable cost areas are—

(A) Compensation of owners.

1. Compensation of services of owners shall be an allowable cost area, provided the services are actually performed, are necessary and are reasonable.

2. Compensation shall mean the total benefit, within the limitations set forth in this rule, received by the owner for the services s/he renders to the facility, including direct

payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this rule. Compensation must be paid (whether in cash, negotiable instrument or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual (PRM)*, Part 1, Section 906.4.

3. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the owner not rendered these services, then employment of another entity to perform the service would be necessary;

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

A. The book value of the provider;

B. Fair market value at the time of acquisition;

C. The recognized Internal Revenue Service (IRS) tax basis; and

D. In the case of change in ownership after July 18, 1984, the cost basis of acquired assets of the owner of record as of July 18, 1984, as of the effective date of the change in ownership or, in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the division as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the Medicaid program and the facility in

ratio to Medicaid recipient reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the Medicaid program need not correspond to the method used by a provider for non-Medicaid purposes; however, useful life shall be in accordance with the *American Hospital Association's Guidelines*. Component part depreciation is optional and allowable under this rule.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under GAAP. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. When a provider has elected, for federal income tax purposes, to expense certain items, such as interest and taxes during construction, the historical cost basis for Medicaid depreciation purposes may include the amount of these expensed items. However, when a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For purposes of this rule, any asset costing less than one thousand dollars (\$1000), or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as described in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the depreciation base if the capital expenditures fail to comply with any federal or state law or regulation, such as CON.

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this rule;

(D) Interest and finance costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for purposes such as working capital



for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions, or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. Interest (including finance charges, prepaid costs and discounts) must be supported by evidence of a written agreement that funds were borrowed and that payment of interest and repayment of the funds are required. The interest costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed and must be necessary and proper for the operation, maintenance or acquisition of the provider's facility.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the market at the time the loan was made.

7. Interest on loans to for-profit providers by proprietors, partners and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C), the interest associated with the portion of the loan(s) which exceeds the asset cost basis as defined in subsection (7)(C) shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per-diem rate.

10. A provider shall amortize finance charges, prepaid interest and discounts over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the period of the loan ratably or by means of the constant rate of interest method.

12. Usual and customary costs shall be limited to the lender's title and recording

fees, appraisal fees, legal fees, escrow fees and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be an allowable cost item if the capital expenditures fail to comply with any federal or state law or regulation, such as CON;

(E) Rental and leases.

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas; provided, that the rented items are necessary and not, in essence, a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties which is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership after July 18, 1984, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or, in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the Medicaid program, shall be a nonallowable cost;

(F) Real estate and personal property taxes levied on or incurred by a facility.

(G) Issuance of revenue bond and tax levies by district and county facilities. For those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be granted as an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a

revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of services of employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost; provided, that the services are not of a religious nature. Building costs on space set aside primarily for professionals providing any religious function shall not be allowable. Costs for wardrobe and similar items likewise are considered nonallowable;

(I) Fringe benefits.

1. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees, excluding stockholders, partners and proprietors of the provider shall be an allowable cost. Interest income from funded pension or qualified retirement plans shall be excluded from revenue offsets.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners and proprietors, under deferred compensation plans shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually



paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost area.

A. Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs.

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable;

(J) Education and training expenses.

1. Except for costs associated with nurse aide training, and competency evaluation programs after October 1, 1990, the cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost only when specifically authorized in advance in writing by the division.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals;

(K) Organizational costs.

1. Organizational costs may be included as an allowable cost, if properly amortized.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. When a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five (5)-year period prior to entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty (60)-month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost;

(L) Advertising costs. Advertising costs which are reasonable and appropriate. The costs must be a common and accepted occurrence for providing LTC services.

(M) Cost of supplies and services involving related parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the uniform cost report, a provider shall identify related party suppliers and the type, the quantity and costs to the related party for goods and services obtained from each supplier.

(N) Utilization review. Costs incurred for the performance of required utilization review.

(O) Minimum utilization. In the event the occupancy rate of a facility is below ninety percent (90%), the following cost centers will be adjusted as though the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, plant operation and general and administrative. In no case may costs disallowed under this provision be carried forward to succeeding periods. Cost centers are expenses grouped in accordance with the headings as identified in the cost report.

(P) Return on equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall not exceed twelve percent (12%) per year.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property and equipment (cost of land, mortgage payments toward principal and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the Medicaid program on the basis of the provider's Medicaid program reimbursable recipient resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost report year;

(Q) Capital.

1. Capital reimbursement will be determined as follows:

A. For facilities entering the program after July 1, 1990, allowable capital is as described in paragraph (7)(Q)2. except the movable equipment rate described in item (7)(Q)2.A.(I)(a)IV. shall be sixty-five cents (65¢) per bed day which equates to two hundred twenty dollars (\$220) per bed;

B. For facilities which entered the program after March 18, 1983, and which were not in operation for two (2) years prior to entering the program, allowable capital is as described in paragraph (7)(Q)2.;

C. For facilities which were in operation for two (2) years prior to entering the program and which entered the program between March 18, 1983 and prior to July 1, 1990, allowable capital shall be depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule; and

D. For facilities which entered the program prior to March 18, 1983, allowable capital shall be depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule.

2. In lieu of depreciation; rent or leases, or both; interest and finance costs; organizational costs; and return on equity as described in the provisions of this rule, allowable capital for facilities described in subparagraphs (7)(Q)1.A. and B. shall be the sum of the building and equipment rate, land rate and working capital rate determined in accordance with the following procedures:

A. The building and equipment rate will be computed in the following way:

(I) Determine the lower of—

(a) Dodge allowable for building and equipment, which is computed as—

I. Reasonable construction or acquisition cost computed by applying the Building Cost Calculator as defined in this rule for the facility geographically closest to St. Louis, Kansas City or Columbia, multiplied by one hundred eight percent (108%) as an allowance for fees authorized as architectural or legal not included in the Building Cost Calculator, multiplied by the square footage of the facility not to exceed three hundred twenty-five (325) square feet per bed;

II. Multiply by a return rate of twelve percent (12%);

III. Divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days; and

IV. Add fifty-three cents (53¢) per bed day to cover the movable equipment,



which equates to one hundred eighty dollars (\$180) per bed divided by the product of ninety-three percent (93%) multiplied by three hundred sixty-five (365) days; or

(b) Actual acquisition cost, which is computed as—

I. Actual acquisition cost, which is the original cost to construct or acquire the building, including fixed and movable equipment, and excluding land costs not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable;

II. Multiply by a return rate of twelve percent (12%);

III. Divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days;

B. The land rate.

(I) The maximum allowable land area is defined as five (5) acres for a facility with one hundred (100) or fewer beds and one (1) additional acre for each additional one hundred (100) beds or fraction of beds for a facility with one hundred one (101) or more beds.

(II) Calculation.

(a) For facilities with land areas at or below the maximum allowable land area, multiply the acquisition cost of the land not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable, by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds multiplied by three hundred sixty-five (365) days.

(b) For facilities with land areas greater than the maximum allowable land area, divide the acquisition cost of the land not to exceed the limitations on reimbursement as set forth in 13 CSR 70-10.100, if applicable, by the total acres, multiply by the maximum allowable land area, multiply by the return rate of twelve percent (12%), divide by ninety-three percent (93%) of the facility's total available beds, multiplied by three hundred sixty-five (365) days;

C. The working capital rate will be twenty cents (20¢) per day. This amount was determined to be the average daily balance due to a facility for services provided to the state with a return rate of twelve percent (12%), divided by ninety-three percent (93%); and

D. If a provider does not provide the actual acquisition cost to determine the building and equipment rate and the land rate, the building and equipment rate will be computed using subpart (7)(Q)2.A.(I)(b), and the land rate will be zero cents (0¢); and

(R) Central office, pooled costs, management company costs. The allowability of the individual cost items contained within central office, pooled costs or management company costs will be determined in accordance with all other provisions of this rule. The total of central office, pooled costs and management company costs, or a combination of these, are limited to seven percent (7%) of revenues.

(8) Nonallowable Costs. Cost not reasonably related to LTC facility services shall not be included in a provider's costs. Contractual allowances, courtesy discounts, charity allowances and similar adjustments or allowances are offsets to revenue and not included in allowable costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, purchased CON, but excluding organizational costs;

(B) Attorney fees related to litigation involving state, local or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators or administrators;

(C) Bad debts;

(D) Capital cost increases due solely to changes in ownership;

(E) Central office or pooled costs not attributable to the efficient and economical operation of the facility;

(F) Charitable contributions;

(G) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this rule;

(H) Costs such as legal fees, accounting and administration costs, travel costs and the costs of feasibility studies which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(I) Directors' fees included on the cost report in excess of two hundred dollars (\$200) per month per individual;

(J) Federal, state or local income and excess profit taxes, including any interest and penalties paid on them;

(K) Late charges and penalties;

(L) Finder's fees;

(M) Fund-raising expenses;

(N) Interest expense on intangible assets;

(O) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(P) Noncovered supplies, services and items as defined in section (6);

(Q) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare PRM* Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owners/administrators will be adjusted on the basis of the high range; owners included in home office costs or management company costs will be adjusted on the high range provided the owner works a minimum of forty (40) hours a week in the home office, management company or owned nursing homes. All others will be calculated on the median range.

2. The salary identified in subparagraph (8)(Q)1.B. will be apportioned on the basis of hours worked in the facility(ies), home office or management company as applicable to total hours reported for all business interests. A forty (40)-hour minimum will be applied if total hours for all business interests are less than forty (40) hours;

(R) Prescription drugs;

(S) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Costs associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(T) Research costs;

(U) Resident personal purchases;

(V) Salaries, wages or fees paid to non-working officers, employees or consultants;

(W) Stockholder relations or stock proxy expenses;

(X) Taxes or assessments for which exemptions are available;

(Y) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(Z) All costs associated with nurse aide training and competency evaluation programs after October 1, 1990.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report if included in gross revenues. These revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;





- 4. Sale of scrap and waste food or materials;
- 5. Rental income;
- 6. Cash, trade, quantity, time and other discounts;
- 7. Purchase rebates and refunds;
- 8. Recovery on insured loss;
- 9. Parking lot revenues;
- 10. Vending machine commissions or profits;
- 11. Sales from drugs to individuals other than Medicaid recipients;
- 12. Interest income to the extent of interest expense;
- 13. Noninterest income from investments;
- 14. Room reservation charges other than covered therapeutic home leave days;
- 15. Barber and beauty shop revenue;
- 16. Private room differential;
- 17. Medicare Part B revenues;
- 18. Personal services;
- 19. Activity income; and
- 20. Revenue recorded for donated services and commodities.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs if that interest is applied to the asset being depreciated.

(C) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(D) Restricted funds designated by the donor for future capital expenditures will not be offset from allowable expenses at any time.

(E) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(F) As applicable, restricted and unrestricted funds will be offset in each cost center, excluding capital costs, in an amount equal to cost center's proportionate share of allowable expense.

(G) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(10) Provider Reporting and Recordkeeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division of Medical Services an Annual Cost Report, Financial and Statistical Report for Nursing Facilities,

including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment under GAAP of capital expenditures is made.

5. Cost reports shall be submitted by the first day of the fourth month following the close of the fiscal period.

6. If requested in writing, one (1) thirty (30)-day extension of the filing date may be granted.

7. If a cost report is more than ten (10) days past due, payment will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation and retain all payments which have been withheld pursuant to this provision.

8. Authenticated copies of agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, within fifteen (15) days of filing the returns;

G. Leases, rental agreements, or both, related to the activities of the provider;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

9. Cost reports must be fully, clearly and accurately completed and all required attachments must be submitted before a cost report is considered complete. If any additional information, documentation or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the provider's receipt of the request, payments may be withheld from the facility until the information is submitted.

10. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of authorization shall be furnished upon request.

2. Cost reports must be notarized by a licensed notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by

\_\_\_\_\_  
(Provider name(s) and number(s))

for the cost report period beginning \_\_\_\_\_, 19\_\_\_\_ and ending \_\_\_\_\_, 19\_\_\_\_, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the



provider in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be maintained separately with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. Each facility shall retain all financial information, data and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual audit of the financial records used to prepare annual cost reports covering, at a minimum the first two (2) full twelve (12)-month fiscal years of their participation in the Medicaid program. For example: A provider begins business in March, they choose a fiscal year of October 1 to September 30, their first cost report will cover March through September.

That cost report may be audited at the option of the provider. The October 1 to September 30 cost report (the first full fiscal year cost report) shall be audited and the next October 1 to September 30 cost report shall be audited. The audits shall be done by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmation of accounts receivable and accounts payable are not required by the plan.

(E) Change in Provider Status.

1. Upon termination of participation in the Medicaid program or change of ownership, the provider is required to submit a cost report for the period ending with the date of termination or change, regardless of its tax period. The fully completed cost report with all required attachments and documentation is due within forty-five (45) days after the date of termination or change.

2. The next payment due the provider after the division has received the notification of the termination or change may be held by the division until the cost report is filed. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the LTC facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that owns, controls or manages one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Allocation of central office or pooled costs to individual facilities shall be consistent from year-to-year. If a desk review or field audit established that records are not maintained so as to clearly identify information required by this rule, those commingled costs shall not be recognized as allowable cost in determining the facility's Medicaid per-diem rate. Allowability of these costs shall be determined in accordance with the provisions of this rule.

(11) Rate Determination. Subject to limitations prescribed elsewhere in these rules, a facility's per-diem rate shall be determined by the division as described in this section.

(A) A facility with a valid Medicaid participation agreement in effect on June 30, 1990, and with a cost report on file with the division as of December 31, 1989, with a period ending in calendar year 1988 shall be

granted a prospective per-diem rate effective for service dates on and after July 1, 1990. This rate will be the greater of the amount determined in the following paragraphs:

1. The allowable cost per patient day as determined by the division from the desk-reviewed or field-audited cost report, or both, with a period ending in calendar year 1988 will be multiplied by one hundred eleven and one-tenth percent (111.1%). One dollar and six cents (\$1.06) will be added to this adjusted cost per patient day amount to allow for the April 1, 1990 change in the minimum wage and the total will be subject to and limited by the ceiling amount of fifty-four dollars and ninety-five cents (\$54.95). The division will use a cost report which has an ending date in calendar year 1988 which is on file with the division as of December 31, 1989, and no amended information will be accepted after that date. If a facility has more than one (1) cost report with periods ending in calendar year 1988, the report covering a full twelve (12)-month period ending in calendar year 1988 will be used. If none of the reports covers twelve (12) months, the report with the latest period ending in calendar year 1988 will be used; or

2. The per-diem rate in effect for services rendered on June 30, 1990.

(B) A facility with a valid Medicaid participation agreement in effect on June 30, 1990, which does not have a cost report with a period ending in calendar year 1988 shall be granted an interim per-diem rate effective for service dates on and after July 1, 1990, equal to the per-diem rate in effect for services rendered on June 30, 1990. A prospective per-diem rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk-reviewed, field-audited, or both, facility fiscal year cost report which covers either the first twelve (12) months of operation under rules applicable at the time the facility entered the Medicaid program or the second twelve (12)-month fiscal year following the initial date of Medicaid certification. The facility must elect the option in writing and it must be received by the Division of Medical Services no later than October 1, 1990. A facility failing to notify the Division of Medical Services of its intent shall have its prospective per-diem rate established on the basis of the second twelve (12)-month facility fiscal year following the initial date of Medicaid certification. This prospective per-diem rate shall be retroactively effective for services beginning on the first day of the facility's option year but not earlier than July



1, 1990, and shall replace the interim per-diem rate on and after that date. Rate adjustment per paragraph (12)(A)1. which may have been granted for service dates on and after the effective date of the prospective per-diem rate will be applied when effective.

(C) Except as provided in subsection (11)(D), a facility entering the Medicaid program after June 30, 1990, shall receive an interim per-diem rate equal to ninety-five percent (95%) of the LTCC in effect on the initial date of Medicaid certification to be effective for services rendered on and after the initial date of Medicaid certification. A prospective per-diem rate will be determined on the basis of the division's determination of the allowable cost per patient day as determined by the division from the desk-reviewed, field-audited, or both, facility fiscal year cost report which covers the second twelve (12)-month fiscal year following the facility's initial date of Medicaid certification for new facilities, and the first twelve (12)-month fiscal year cost report for facilities entering the Medicaid program after June 30, 1990, which are not new facilities. This prospective per-diem rate shall be effective retroactively for services beginning on the first day of the new facility's second twelve (12)-month fiscal year and the first day of the facility's first twelve (12)-month fiscal year for facilities entering the Medicaid program after June 30, 1990, which are not new facilities and shall replace the interim per-diem rate on and after that date. Rate adjustment per paragraph (12)(A)1. which may have been granted for service dates on and after the effective date of the prospective per-diem rate will be applied when effective.

(D) A facility with a valid Medicaid participation agreement in effect on or after July 1, 1990, which either voluntarily or involuntarily terminates its participation in the Medicaid program and which reenters the Medicaid program shall have its prospective per-diem rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in paragraph (12)(A)1. This prospective per-diem rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(12) Adjustments to the Per-Diem Rate. Subject to the limitations prescribed elsewhere in these rules, a facility's per-diem rate may be adjusted as described in this section.

(A) Adjustments determined by the division without the advice of the rate advisory committee.

1. Global per-diem rate adjustments. Global per-diem rate adjustments shall be added to the LTCC. All facilities with valid Medicaid participation agreements in effect on the effective date of the adjustments shall be eligible for the global per-diem rate adjustments. A facility with either an interim rate or a prospective per-diem rate may qualify for the global per-diem rate adjustments as follows:

A. Laundry. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on July 1, 1990, per subsections (11)(A) and (B) shall be granted an increase to their per-diem rate effective July 1, 1990, of fifty cents (50¢) per patient day related to personal laundry;

B. Negotiated trend factor. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on July 1, 1990, per subsections (11)(A) and (B) shall be granted an increase to their per-diem rate effective July 1, 1990, of forty-seven cents (47¢) per patient day for the negotiated trend factor. This amount is one percent (1%) of the average per-diem rate paid to all facilities on April 30, 1990;

C. Minimum wage adjustment. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on April 1, 1991, per subsections (11)(A) (C) shall be granted an increase to their per diem of one dollar and six cents (\$1.06) effective April 1, 1991, to allow for the April 1, 1991 change in minimum wage. This amount is two and one-tenth percent (2.1%) of the weighted average per-diem rate paid to all facilities on February 28, 1991;

D. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per-diem rate in effect on July 1, 1992, shall be granted an increase to their per-diem rate effective July 1, 1992, of three dollars and ninety-six cents (\$3.96) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the weighted average per-diem rate of fifty-two dollars and eighty-two cents (\$52.82) for January 1992;

E. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per-diem rate in effect on July 1, 1992, shall be granted an increase to their per-diem rates effective July 1, 1992, of seventy-four cents (74¢) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%)

of the weighted average per-diem rate of fifty-two dollars and eighty-two cents (\$52.82) for January 1992; and

F. Workers' Compensation. All facilities with either an interim per-diem rate or a prospective per-diem rate in effect on January 1, 1994, shall be granted an increase to their per-diem rate effective January 1, 1994, of thirty-eight cents (38¢) per patient day related to Workers' Compensation.

2. Special per-diem rate adjustments. Special per-diem rate adjustments shall not be added to the LTCC. Only those facilities qualifying for special per-diem rate adjustments are eligible for the special per-diem rate adjustments as follows:

A. Nursing home reform.

(I) ICFs. A facility certified for participation as an ICF as of June 30, 1990, or a facility certified after January 1, 1990, as an SNF which did not apply for a change-in-level-of-care adjustment as of June 30, 1990, may be granted the consultant adjustment described in subpart (12)(A)2.A.(I)(a) effective for service dates on and after July 1, 1990. A facility qualifying for the consultant adjustment must apply between July 1, 1990, and December 31, 1990, in order to be considered for or receive the registered nurse (RN) or the licensed practical nurse (LPN) adjustment, or both, described in subparts (12)(A)2.A.(I)(b) and (c), which will be effective beginning on the application date but no earlier than July 1, 1990, subject to applicable waivers. A facility must demonstrate by September 1, 1992, that they have hired the RNs and LPNs for which they have received an adjustment by submitting a consecutive two (2)-week staffing pattern between the effective date of the adjustment and May 1, 1992; and, to the extent that a facility does not demonstrate by that staffing pattern that it hired the RNs, LPNs, or both, for which it received an adjustment under subparts (12)(A)2.A.(I)(b) and (c), that facility's rate will be reduced by the undemonstrated portion of the adjustment, both retroactive to the effective date of the adjustment and prospectively, and the overpayment will be recouped. These are one (1)-time adjustments.

(a) Consultant adjustment. One dollar (\$1) will be added to the per-diem rate in effect on July 1, 1990, for qualifying facilities to allow for consultant requirements. This amount was derived from the 1988 SNF consultant costs converted to a weighted mean cost per patient day and then increased by twenty percent (20%).

(b) RN adjustment. An RN is required for eight (8) consecutive hours, seven (7) days a week. The RN requirement



will be compared to a facility's RN staffing as documented on the 1988 staffing reports (DOA 184) on file as of December 31, 1989, with the Division of Aging. If a facility does not have 1988 staffing reports, the latest report on file as of June 30, 1990, will be used. The difference between the daily RN requirement and the average daily RN staffing per the DOA 184s will be determined and multiplied by a per-hour rate of sixteen dollars and eighty-one cents (\$16.81) to arrive at total daily cost. The per-hour rate was derived from 1988 RN rates for ICFs, including fringe benefits at fifteen percent (15%) and then increased by twenty percent (20%). If the total daily cost is positive, it will be divided by average daily licensed occupied beds or ninety percent (90%) of licensed beds, whichever is greater to obtain the RN adjustment to the per-diem rate in effect on July 1, 1990. Occupancy data will be obtained from the fourth quarter 1989 occupancy statistics of the Division of Aging or the most recent data if fourth quarter 1989 occupancy statistics are not available for the facility.

(c) LPN adjustments. For a facility with average daily occupancy of sixty (60) or fewer residents, eight (8) hours of LPN coverage is required for each of two (2) eight (8)-hour shifts seven (7) days a week, except in cases when the RN requirement is waived. If the RN requirement is waived and the facility has average daily occupancy of sixty (60) or fewer residents, eight (8) hours of LPN coverage is required for each of three (3) eight (8)-hour shifts seven (7) days a week. For a facility with occupancy in excess of sixty (60) residents, eight (8) hours of LPN coverage is required for each of three (3) eight (8)-hour shifts seven (7) days a week. The LPN requirement will be compared to the facility's LPN staffing as documented on the 1988 staffing reports (DOA 184) on file as of December 31, 1989, with the Division of Aging. If a facility does not have 1988 staffing reports, the latest report on file as of June 30, 1990, will be used. The difference between the daily LPN requirement and the average daily LPN staffing per the DOA 184s will be determined and multiplied by a per-hour rate of ten dollars and eighty-three cents (\$10.83) to arrive at total daily cost. The per-hour rate was derived from 1988 LPN rates for ICFs, including fringe benefits at fifteen percent (15%) and then increased by twenty percent (20%). If the total daily cost is positive, it will be divided by average daily licensed occupied beds or ninety percent (90%) of licensed beds, whichever is greater to obtain the LPN adjustment to the per-diem rate in effect on July 1, 1990. Occupancy

data will be obtained from this fourth quarter 1989 occupancy statistics of the Division of Aging or the most recent data if fourth quarter 1989 occupancy statistics are not available for the facility; and

B. High volume provider. A facility must qualify each July 1 for the high volume adjustment. For a facility which has a high volume adjustment on June 30, 1994, and does not qualify July 1, 1994, that facility's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective per-diem rate in effect June 30, 1994. The adjustment will be effective for services rendered between July 1, 1994 through June 30, 1995. Effective with the state's Fiscal Year 1996, the division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

(I) A facility must meet all four (4) of the following qualifications:

(a) A full twelve (12)-month cost report ending in calendar year 1992. For a nonprofit facility that changed ownership or operator, or both, and filed a partial year cost report, the latest period cost report will be considered as a full twelve (12)-month cost report;

(b) One hundred six and two-tenths percent (106.2%) of the allowable cost per patient day as determined by the division from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds the LTCC in effect June 30, 1994, as identified in paragraph (3)(E)3.;

(c) Total occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds eighty-five percent (85%) of licensed beds or facilities that had a high volume adjustment on June 30, 1994, and had total occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeding eighty-three percent (83%) of licensed beds. If the facility did not include all licensed beds on the cost report, this qualifier will be determined from the Division of Aging quarterly report of licensed occupancy for the 1992 quarter which ends on an ending date closest to the ending date of the cost report; and

(d) Medicaid-occupied beds as determined from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds eighty percent (80%) of the total licensed occupied beds identified in subpart (12)(A)2.B.(I)(c) or provide at minimum sixty-five thousand (65,000) Missouri Medicaid patient days as determined from the cost report identified in subpart (12)(A)2.B.(I)(a).

(II) The adjustment will be equal to ten percent (10%) of the LTCC which was in

effect June 30, 1994. This amount was six dollars and twenty-one cents (\$6.21).

(III) If a facility qualifies for the high volume adjustment, their LTCC adjustment will be six dollars and twenty-one cents (\$6.21) above the LTCC in effect for services rendered between July 1, 1994 through June 30, 1995;

C. 1967 *Life Safety Code* (LSC). Currently certified LTC facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their Medicaid per-diem rate. The reimbursement shall not be effective until the Division of Aging has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The nursing home's rate plus this adjustment will be limited to the Medicaid LTCC per subpart (12)(A)2.B.(I)(a). The division will use a cost report with the latest period ending in calendar year 1992 which is on file with the division as of July 1, 1993. This adjustment will be computed as follows based on the cost documented and submitted to the Division of Medical Services:

(I) Depreciation. The asset value for the actual cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

(II) Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period; and

(III) The total of the result of depreciation and interest will be divided by twelve (12) and then multiplied by the number of months covered by the 1991 cost report. This amount will be divided by the greater of actual patient days from the 1991 cost report or ninety percent (90%) of the available bed days from the 1991 cost report;

D. Effective March 1, 1993, any nursing facility licensed under Chapter 198, RSMo and operated by a district or county which receives local tax revenues and certifies these revenues to the Department of Social Services shall receive an adjustment to their per-diem rate. The adjustment shall not exceed ninety percent (90%) of the Medicaid portion of the local tax revenues in aggregate



divided by the total projected Medicaid payments for FY-93 for those qualifying facilities. The adjustment will be limited by the class ceiling. Any unused certified local tax revenues will not carry forward into the next state fiscal year's calculation.

(I) The Medicaid portion is determined by multiplying the total local tax revenues certified to the Department of Social Services for each facility by each facility's Medicaid occupancy rate as reported on their 1990 cost report.

(II) The projected Medicaid payments for FY-93 are computed by multiplying the per-diem rate on record with Division of Medical Services for September 1992 times the projected FY-93 Medicaid days for each qualifying facility allocated based on its February 1992 Medicaid census annualized; and

E. Effective July 1, 1993, and each July 1 after that, any nursing facility licensed under Chapter 198, RSMo and operated by a district or county which receives local tax revenues and certifies these revenues to the Department of Social Services shall receive an adjustment to its per-diem rate. The adjustment shall not exceed ninety percent (90%) of the Medicaid portion of the local tax revenue in aggregate divided by the total projected Medicaid payments for those qualifying facilities. The adjustment will be limited by the class ceiling. Any unused certified local tax revenue will not carry forward into the next state fiscal year's calculation.

(I) The Medicaid portion is determined by multiplying the total local tax revenues certified to the Department of Social Services for each facility by each facility's Medicaid occupancy rate as reported on its most recent desk-reviewed cost report.

(II) The projected Medicaid payments are computed by multiplying the per-diem rate on record with DMS on June 1 each year times the June 1 of each year projected Medicaid days for the following state fiscal year for each qualifying facility allocated based on its reported Medicaid days on the most current cost report on file with DMS.

3. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nursing homes with a current provider agreement on file with the DMS as of October 1, 1991, except those facilities that are owned or operated, or both, by the federal government.

A. For nursing homes which qualify, the PPA shall be the lesser of—

(I) The nursing home's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjust-

ment factor (PPAF) times the LTCC on October 1, 1991, (FPGF × PPD × PPAF × LTCC). For example: A nursing home having two thousand seven (2007) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of two million one hundred seventy-five thousand two hundred fifty-seven (2,175,257) represents an FPGF of nine-hundredths percent (.09%). So using the FPGF of .09% × 9,750,000 × 32.5% × \$56.98=\$167,578; or

(II) The nursing home's FPGF times one hundred forty-five percent (145%) of the amount credited to the nursing facility revenue collection center (NFRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

B. FPGF is determined by using each nursing home's paid days for the service dates in May 1991 through July 1991 as of August 20, 1991, divided by the sum of the paid days for the same service dates for all nursing homes qualifying as of the determination date of September 12, 1991.

C. LTCC is fifty-six dollars and ninety-eight cents (\$56.98) on October 1, 1991.

D. PPAF is equal to thirty-two and five-tenths percent (32.5%) for Fiscal Year 1992 which includes an adjustment for economic trends, Workers' Compensation and heavy care/access incentive.

E. PPD is the projection of nine million seven hundred fifty thousand (9,750,000) patient days made on October 1, 1991, for the adjustment year.

4. Other conditions for per-diem rate adjustments. The division may adjust a facility's per-diem rate both retrospectively and prospectively under the following conditions:

A. Fraud, misrepresentation, errors, audit adjustment. When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of that information. No decision by the Medicaid agency to impose a rate adjustment in the case of fraudulent, misrepresented or inaccurate information in any way shall affect the Medicaid agency's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of this information also does not affect the Medicaid

agency's ability to impose any sanctions authorized by statute or regulation;

B. Decisions of the Administrative Hearing Commission or settlement agreements approved by the Administrative Hearing Commission;

C. Court order; and

D. Disallowance of federal financial participation.

(B) Adjustments Determined by the Division With the Advice of the Rate Advisory Committee.

1. Advisory committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to requests for rate reconsideration which are in accordance with the provisions of paragraph (12)(B)2. The director may accept, reject or modify the advisory committee's recommendations.

A. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department of Social Services and two (2) members who may include, but are not limited to, a consumer representative, an accountant or economist or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

B. Procedures.

(I) The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concurs.

(II) The committee shall meet no less than one (1) time each quarter and members shall be reimbursed for expenses.

(III) The Division of Medical Services will summarize each case and make recommendations. The advisory committee may request additional documentation. Failure to submit requested documentation shall be abandonment of the request.

(IV) The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

(V) The advisory committee shall have ninety (90) days from the receipt of each complete request, or the receipt of any additional documentation, to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee



establishes good cause, may grant a reasonable extension.

(VI) Final determination on rate adjustment. The director or his/her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

(VII) If the director or his/her designee's final determination allows a rate adjustment, it shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month.

2. Requests for rate adjustments. A participating facility which has a prospective per-diem rate may request adjustment to its prospective per-diem rate only under the conditions described in subparagraph (12)(B)2.A., B. or C. The request must be submitted in writing to the division within one year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify under which of the conditions the rate adjustment is sought. The total dollar amount of the requested rate adjustment must be supported by complete, accurate and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month. Conditions for rate adjustment are—

A. Extraordinary circumstances.

(I) When the provider can show that it incurred higher costs due to circumstances beyond its control; the circumstances were not experienced by the nursing home industry in general; and the costs have a substantial effect.

(II) Extraordinary circumstances include:

(a) Natural disasters; such as fire, earthquakes and flood; 1) that are not

covered by insurance; and 2) that occur in a federally-declared disaster area; and

(b) Vandalism, civil disorder or both.

(III) The per-diem rate increase will be calculated as follows:

(a) To determine what portion of the incurred costs will be paid by the Division of Medical Services, the division will use the quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstance occurred;

(b) For one (1)-time costs (costs which will not be incurred in future fiscal years): The costs directly associated with the extraordinary circumstance will be divided by the paid days for the month the rate adjustment becomes effective per part (12)(B)1.B.(VII). This calculation will equal the amount to be added to the per-diem rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one month only, the LTCC will be waived; and

(c) For on-going or capitalized costs (costs that will be incurred in future fiscal years): Ongoing annual costs (that is, depreciation, interest, etc.) will be divided by the greater of: annualized (calculated for a twelve (12)-month period) total patient days from the latest cost report on file or ninety percent (90%) of annualized total bed days. This calculation will equal the amount to be added to the per-diem rate, not to exceed the LTCC in effect on the date of the increase. This rate adjustment will be added to the per-diem rate;

B. Professional service hours. A rate adjustment may be granted if a facility has experienced an increase in total RN and LPN hours. This increase divided by patient days from the latter period must be at least twenty percent (20%) of the average total RN and LPN hours per patient day for the appropriate period. For adjustments requested in state FY-92, this average will be derived from total RN and LPN hours as identified from cost reports for facilities licensed as SNFs with ending dates after July 1, 1990, and prior to January 1, 1991. For each succeeding state fiscal year, this average will be derived from total RN and LPN hours as identified from cost reports with ending dates in the second calendar year prior to the ending date of the state fiscal year. For example, adjustments requested in state FY-93, the data from cost reports with ending dates in calendar year 1991 will be used. This adjustment is available no more frequently than every two (2) years, with the first adjustment available under this plan to be based upon the twelve

(12)-month facility fiscal year required cost report with a period ending after the effective date of this rule. This cost report will be compared to the required cost report for the succeeding twelve (12)-month facility fiscal year. For example, a facility with a twelve (12)-month cost report ending September 30, 1990, shall compare total RN and LPN hours corresponding to RN and LPN salaries reported on lines forty-nine (49) and fifty (50) of the cost report plus contracted RN and LPN hours corresponding to the contracted costs identified on the cost report, to similar data from the cost report for the twelve (12)-month period ending September 30, 1991. The next available adjustment would be for the twelve (12)-month facility fiscal year required cost report with a period ending September 30, 1993, as compared to the required cost report for the twelve (12)-month period ending September 30, 1991. The adjustment amount will be determined by obtaining the difference in costs per patient day reported for RN and LPN services (salaries, fringe benefits and RN and LPN contract costs) between the two (2) applicable cost reporting periods using the greater of ninety percent (90%) of bed days or actual reported occupancy. The facility must submit copies of the actual payroll records which support the cost report data as well as billings showing RN and LPN contract hours which support the cost report. These records must show job title (RN, LPN), actual hours worked, the per-hour rate and the total amount paid for each employee. Any salaried RN or LPN employee will be assumed to be working a forty (40)-hour week for all weeks worked; and

C. Additional beds. The division may recommend a rate adjustment for a participating facility which has a prospective per-diem rate in effect, and which increases its bed capacity after July 1, 1990, in accordance with an approved CON or applicable waiver. The recommended rate adjustment will be calculated as the difference between the weighted average allowable capital costs per day as defined in part (12)(B)2.C.(I) and the allowable capital cost per day as determined in subsection (7)(Q).

(I) The weighted average allowable capital cost per day is calculated as the sum of subparts (12)(B)2.C.(I)(a) and (b) divided by the total number of certified beds.

(a) The allowable capital cost per day as determined in subsection (7)(Q) multiplied by the number of existing certified beds.

(b) The allowable capital cost per day for new beds as described in paragraph (7)(Q)2. multiplied by the number of new certified beds, except the movable equipment



rate described in subparagraph (7)(Q)2.B. shall be sixty-five cents (65¢) per bed day which equates to two hundred twenty dollars (\$220) per bed.

(13) Exceptions.

(A) For those Medicaid-eligible recipient patients who have concurrent Medicare Part A SNF benefits available, Missouri Medical Assistance Program reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of fewer than one thousand (1000) patient days for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provided services of one thousand (1000) or more patient days for Missouri Title XIX recipients, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate as calculated in section (11).

(14) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this rule, the division also may impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(15) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may seek a hearing before the Administrative Hearing Commission of final decisions of the director, Department of Social Services or the Division of Medical Services.

(16) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these rules and applicable covenants.

(17) Provider Participation. Payments made in accordance with the standards and methods

described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the state plan at least to the extent these services are available to the general public.

(18) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this rule.

APPENDIX A Covered Supplies & Services

Personal Care—

- Baby Powder
Bedside Tissues
Bids (all types)
Deodorants
Disposable Underpads (all types)
Gowns, Hospital
Hair Care, Basic (including washing, cuts, sets, brushes, combs, nonlegend shampoo)
Lotion, Soap and Oil
Nail Clipping and Cleaning Routine
Oral Hygiene (including denture care, cups, cleaner, mouthwashes, toothbrushes and paste)
Shaves, Shaving Cream and Blades

Equipment—

- Arm Slings
Basins
Bathing Equipment
Bed Frame Equipment (including trapeze bars and bedrails)
Bed Pans (all types)
Beds, Manual, Electric
Canes (all types)
Crutches (all types)
Foot Cradles (all types)
Glucometers
Heat Cradles
Heating Pads
Hot Pack Machines
Hypothermia Blanket
Mattresses (all types)
Patient Lifts (all types)
Respiratory Equipment (compressors, vaporizers, Humidifiers, Intermittent Positive Pressure Breathing Machines (IPPB), nebulizers, suction equipment and related supplies and the like)
Restraints
Sand Bags
Specimen Container (cup or bottle)
Urinals (male and female)
Walkers (all types)
Water Pitchers
Wheelchairs (standard, geriatric and rollabout)

Nursing Care/Patient Care Supplies—

- Catheter (indwelling and nonlegend supplies)
Decubitus Ulcer Care (pads, dressings, air mattresses, aquamatic K-pads (water-heated pads), alternating pressure pads, flotation pads, or turning frames, or any combination of these, heel protectors, donuts and sheepskins)
Diabetic Blood and Urine Testing Supplies
Douche Bags
Drainage Sets, Bags, Tubes and the like
Dressing Trays (dressings of all types)
Enema Supplies
Gloves (nonsterile and sterile)
Ice Bags
Incontinency Care (including pads, diapers and pants)
Irrigation Trays and Nonlegend Supplies
Medicine Cups
Medicine Droppers
Needles (including, but not limited to, hypodermic, scalp, vein)
Nursing Services (regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel)
Nursing Supplies: Lubricating Jelly,, Beta-dine,Benzoin, Peroxide, A & D Ointment, Tapes, Alcohol, Alcohol Sponges, Applicators, Dressings and Bandages (of all types), Cottonballs, Merthiolate Aerosol and Tongue Depressors
Ostomy Supplies (adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures and bags)
Suture Care (including trays and removal kits)
Syringes, all sizes and types (including Ascepto)
Tape (for laboratory tests)
Urinary Drainage Tube and Bottle

Therapeutic Agents and Supplies— Antacids, Nonlegend

- Drugs, Stock (excluding Insulin)
Enteral Feedings (including by tube, and all related supplies)
I.V. Therapy Supplies (arm boards, needles, tubing and other related supplies)
Laxatives, Nonlegend
Oxygen (portable or stationary), Oxygen Delivery Systems, Concentrators and Supplies
Special Diets
Stool Softeners, Nonlegend
Vitamins, Nonlegend

Other Services and Supplies as Otherwise Determined



*AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 1994.\* This rule was previously filed as 13 CSR 40-81.081. Emergency rule filed Sept. 18, 1981, effective Oct. 1, 1981, expired Jan. 13, 1982. Original rule filed Sept. 18, 1981, effective Jan. 14, 1982. Emergency amendment filed Sept. 28, 1981, effective Oct. 7, 1981, expired Jan. 13, 1982. Amended: Filed Oct. 13, 1981, effective Jan. 14, 1982. Emergency amendment filed June 21, 1982, effective July 1, 1982, expired Oct. 10, 1982. Amended: Filed June 21, 1982, effective Oct. 11, 1982. Emergency amendment filed Oct. 8, 1982, effective Oct. 18, 1982, expired Jan. 12, 1983. Amended: Filed Oct. 8, 1982, effective Jan. 13, 1983. Amended: Filed March 14, 1985, effective July 11, 1985. Emergency amendment filed June 20, 1985, effective July 1, 1985, expired Sept. 30, 1985. Amended: Filed June 20, 1985, effective Oct. 1, 1985. Amended: Filed Aug. 2, 1985, effective Nov. 1, 1985. Amended: Filed Dec. 16, 1985, effective April 25, 1986. Amended: Filed April 16, 1986, effective July 1, 1986. Amended: Filed June 17, 1986, effective Sept. 1, 1986. Emergency amendment filed June 30, 1986, effective July 10, 1986, expired Nov. 7, 1986. Amended: Filed July 3, 1986, effective Oct. 11, 1986. Amended: Filed July 3, 1986, effective Nov. 1, 1986. Amended: Filed Aug. 1, 1986, effective Nov. 13, 1986. Amended: Filed Dec. 16, 1986, effective April 26, 1987. Emergency amendment filed June 19, 1987, effective July 1, 1987, expired Oct. 29, 1987. Emergency amendment filed Aug. 18, 1987, effective Aug. 28, 1987, expired Dec. 25, 1987. Amended: Filed Aug. 18, 1987, effective Dec. 12, 1987. Amended: Filed Aug. 18, 1987, effective Oct. 25, 1987. Emergency amendment filed July 28, 1988, effective Aug. 6, 1988, expired Dec. 3, 1988. Emergency amendment filed Oct. 4, 1988, effective Oct. 14, 1988, expired Dec. 4, 1988. Amended: Filed Dec. 5, 1988, effective Feb. 24, 1989. Emergency amendment filed Dec. 16, 1988, effective Jan. 1, 1989, expired May 1, 1989. Amended: Filed Dec. 16, 1988, effective March 11, 1989. Amended: Filed March 3, 1989, effective May 15, 1989. Amended: Filed Aug. 16, 1989, effective Nov. 11, 1989. Amended: Filed March 5, 1990, effective June 11, 1990. Emergency rescission and rule filed June 1, 1990, effective July 1, 1990, expired Oct. 28, 1990. Rescinded and readopted: Filed June 1, 1990, effective Sept. 28, 1990. Emergency amendment filed March 4, 1991, effective April 1, 1991, expired July 29, 1991. Amended: Filed March 4, 1991, effective July 8, 1991. Amended: Filed March 18, 1991, effective July 8, 1991. Amended: Filed May 2, 1991, effective Sept. 30, 1991.*

*Emergency amendment filed June 20, 1991, effective July 1, 1991, expired Oct. 28, 1991. Amended: Filed June 26, 1991, effective Dec. 9, 1991. Amended: Filed Sept. 4, 1991, effective Jan. 13, 1992. Emergency amendment filed Oct. 9, 1991, effective Oct. 29, 1991, expired Feb. 25, 1992. Emergency amendment filed Nov. 15, 1991, effective Dec. 3, 1991, expired April 1, 1992. Amended: Filed Nov. 15, 1991, effective April 9, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Amended: Filed Feb. 3, 1992, effective June 25, 1992. Amended: Filed March 30, 1992, effective Sept. 6, 1992. Amended: Filed May 5, 1992, effective Jan. 15, 1993. Amended: Filed May 15, 1992, effective Jan. 15, 1993. Emergency amendment filed June 16, 1992, effective July 1, 1992, expired Oct. 28, 1992. Emergency amendment filed June 16, 1992, effective July 1, 1992, expired Oct. 28, 1992. Emergency amendment filed June 26, 1992, effective July 5, 1992, expired Oct. 28, 1992. Emergency amendment filed July 23, 1992, effective Aug. 2, 1992, expired Nov. 29, 1992. Emergency amendment filed July 23, 1992, effective Aug. 2, 1992, expired Nov. 29, 1992. Emergency amendment filed Sept. 25, 1992, effective Oct. 29, 1992, expired Feb. 25, 1993. Emergency amendment filed Sept. 25, 1992, effective Nov. 1, 1992, expired Feb. 27, 1993. Emergency amendment filed Nov. 16, 1992, effective Nov. 30, 1992, expired March 29, 1993. Emergency amendment filed Nov. 16, 1992, effective Nov. 30, 1992, expired March 29, 1993. Amended: Filed June 16, 1992, effective Feb. 26, 1993. Amended: Filed Sept. 25, 1992, effective May 6, 1993. Amended: Filed Oct. 15, 1992, effective May 6, 1993. Emergency amendment filed Feb. 18, 1993, effective March 1, 1993, expired June 28, 1993. Amended: Filed Feb. 5, 1993, effective July 8, 1993. Emergency amendment filed Feb. 16, 1993, effective Feb. 26, 1993, expired June 25, 1993. Emergency amendment filed Feb. 16, 1993, effective Feb. 28, 1993, expired June 27, 1993. Amended: Filed Feb. 18, 1993, effective Sept. 9, 1993. Emergency amendment filed June 15, 1993, effective July 1, 1993, expired Oct. 28, 1993. Emergency amendment filed May 20, 1993, effective June 1, 1993, expired Sept. 28, 1993. Emergency amendment filed June 15, 1993, effective June 30, 1993, expired Oct. 27, 1993. Emergency amendment filed Aug. 17, 1993, effective Sept. 1, 1993, expired Dec. 29, 1993. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed June 15, 1993, effective Dec. 9, 1993. Emergency amendment filed Aug. 17, 1993, effective Sept. 1, 1993, expired Dec. 29, 1993. Emer-*

*gency amendment filed Oct. 15, 1993, effective Oct. 29, 1993, expired Feb. 25, 1994. Amended: Filed Aug. 17, 1993, effective March 10, 1994. Amended: Filed Nov. 2, 1993, effective June 6, 1994. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 30, 1994. Emergency amendment filed Dec. 17, 1993, effective Jan. 1, 1994, expired April 28, 1994. Amended: Filed Dec. 2, 1993, effective July 30, 1994. Emergency amendment filed April 19, 1994, effective May 1, 1994, expired Aug. 28, 1994. Amended: Filed Feb. 16, 1994, effective Aug. 28, 1994. Emergency amendment filed June 15, 1994, effective July 1, 1994, expired Oct. 28, 1994. Emergency amendment filed Sept. 20, 1994, effective Oct. 1, 1994, expired Jan. 28, 1995. Emergency amendment filed Oct. 7, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Amended: Filed June 15, 1994, effective Jan. 29, 1995. Emergency amendment filed Sept. 20, 1994, effective Oct. 1, 1994, expired Jan. 28, 1995. Emergency amendment filed Oct. 7, 1994, effective Oct. 29, 1994, expired Feb. 25, 1995. Amended: Filed Sept. 20, 1994, effective May 28, 1995.*

*\*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1987.*





DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED  
OMB NO. 0938-0067

QUARTERLY MEDICAID STATEMENT OF EXPENDITURES  
FOR THE MEDICAL ASSISTANCE PROGRAM

STATE \_\_\_\_\_  
AGENCY \_\_\_\_\_  
QUARTER ENDED \_\_\_\_\_, 19\_\_

CERTIFICATION

FORM HCFA-64 SUMMARY SHEET SUBMITTED	MEDICAL ASSISTANCE PAYMENTS		STATE AND LOCAL ADMINISTRATION	
	TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)	TOTAL COMPUTABLE (c)	FEDERAL SHARE (d)
NET EXPENDITURES REPORTED ON LINE 11.				

I, EXECUTIVE OFFICER OF THE STATE AGENCY CHARGED WITH THE DUTIES OF ADMINISTERING (OR SUPERVISING THE ADMINISTRATION OF) THE STATE PLAN FOR THE MEDICAID PROGRAM AS PROVIDED FOR IN THE SOCIAL SECURITY ACT, AS AMENDED, DO CERTIFY THAT THE INFORMATION SHOWN ON THE FORM HCFA-64 SUMMARY SHEET AND THE SUPPORTING FORMS AND SCHEDULES IS CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

DATE \_\_\_\_\_, 19\_\_  
SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_

FORWARD THE COMPLETED QUARTERLY STATEMENT OF EXPENDITURES (SUMMARY SHEET) WITH SUPPORTING COMPUTATION FORM(S) AND SCHEDULE(S) TO THE HEALTH CARE FINANCING ADMINISTRATION, BUREAU OF QUALITY CONTROL, OMM, DFM, BUDGET AND GRANTS BRANCH, P.O. BOX 26678, ROOM 281 EAST HIGH RISE, BALTIMORE, MARYLAND 21207-0278.  
IF YOU TRANSMITTED YOUR FORMS USING THE AUTOMATED MEDICAID BUDGET AND EXPENDITURE SYSTEM, FORWARD ONLY A COMPLETED CERTIFICATION SHEET.



FORM APPROVED  
OMR NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

QUARTERLY MEDICAID STATEMENT OF EXPENDITURES  
FOR THE MEDICAL ASSISTANCE PROGRAM  
SUMMARY SHEET

SECTION A QUARTERLY STATUS OF FUNDING	MEDICAL ASSISTANCE PAYMENTS		STATE AND LOCAL ADMINISTRATION TOTAL COMPUTABLE (c)	FEDERAL SHARE (d)
	TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)		
1. AWARDS RECEIVED DURING THE QUARTER FOR THE QUARTER BEING REPORTED AND PRIOR QUARTERS				
2. AWARDS RECEIVED DURING THE QUARTER FOR SUBSEQUENT QUARTER				
3. INTEREST				
A. RECEIVED ON MEDICAID RECOVERIES				
B. ASSESSED ON DISALLOWANCES				
4. MEDICARE OVERPAYMENT COLLECTIONS UNDER SEC. 1914 AND 42 C.F.R. 447.30				
5.				
SECTION B EXPENDITURES REPORTED FOR PERIOD				
6. EXPENDITURES IN THIS QUARTER (ATTACH 64.9 AND/OR 64.10)				
7. ADJUSTMENTS INCREASING CLAIMS FOR PRIOR QUARTERS (ATTACH 64.9p AND/OR 64.10p)				
8. OTHER EXPENDITURES (ATTACH 64.9p AND/OR 64.10p)				
9. COLLECTIONS:				
A. THIRD PARTY LIABILITY COLL. (ATTACH 64.9a)				
B. PROBATE COLLECTIONS				
C. COLLECTIONS IDENTIFIED THROUGH FRAUD AND ABUSE EFFORT				
D. OTHER COLLECTIONS				
F.				
10. ADJUSTMENTS DECREASING CLAIMS FOR PRIOR QUARTERS:				
A. FEDERAL AUDIT (ATTACH 64.9p AND/OR 64.10p)				
B. OTHER (ATTACH 64.9p AND/OR 64.10p)				
C. OVERPAYMENT ADJUSTMENTS (ATTACH 64.9e)				
11. NET EXPENDITURES REPORTED IN THIS PERIOD (SUM OF ITEMS 6, 7, AND 8 LESS 9 AND 10)				



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE  
MEDICAL ASSISTANCE PROGRAM  
EXPENDITURES IN THIS QUARTER

TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	FMAP %	I.H.S. FACILITY SERVICES 100% (c)	FEDERAL SHARE		TOTAL FEDERAL SHARE (f)
				FAMILY PLANNING SERVICES 90% (d)	% (e)	
1. A. INPATIENT HOSPITAL SERVICES						.19
8. MENTAL HEALTH FACILITY SERVICES						
C. SKILLED NURSING FACILITY SERVICES						
D. INTERMEDIATE CARE FACILITY SERVICES: (1) MENTALLY RETARDED a. PUBLIC PROVIDERS b. PRIVATE PROVIDERS  (2) ALL OTHER						
E. PHYSICIANS' SERVICES						
F. OUTPATIENT HOSPITAL SERVICES						
G. PRESCRIBED DRUGS						
H. DENTAL SERVICES						
I. OTHER PRACTITIONERS' SERVICES						
J. CLINIC SERVICES						
K. LABORATORY AND RADIOLOGICAL SERVICES						



FORM APPROVED  
OMB NO. 0938-0057

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE  
MEDICAL ASSISTANCE PROGRAM  
EXPENDITURES IN THIS QUARTER

	TOTAL COMPUTABLE (a)	FMAP %	I.H.S. FACILITY SERVICES 100% (c)	FEDERAL SHARE		TOTAL FEDERAL SHARE (f)
				FAMILY PLANNING SERVICES 90% (d)	QUARTER ENDED , 19	
MEDICAL ASSISTANCE PAYMENTS TYPE OF WAIVER WAIVER NUMBER						
L HOME HEALTH SERVICES						
M. STERILIZATIONS						
N. ABORTIONS NO.						
O EPSDT SCREENING SERVICES						
P. RURAL HEALTH CLINIC SERVICES						
Q. HEALTH INSURANCE PAYMENTS: (1) PART B PREMIUMS (2) COINSURANCE AND DEDUCTIBLES (3) OTHER						
R. HOME AND COMMUNITY-BASED SERVICES <sup>1</sup>						
S. PERSONAL CARE SERVICES						
T. TARGETED CASE MANAGEMENT SERVICES						
U. HOSPICE BENEFITS						
V. OTHER CARE SERVICES						
W						
2. TOTAL ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET, LINE 6. COLUMNS (a) AND (b).						

<sup>1</sup> IF STATE HAS MORE THAN ONE APPROVED HCBS WAIVER, ATTACH SCHEDULE SHOWING EXPENDITURES FOR EACH APPROVED WAIVER.



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

MEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE  
MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS

STATE \_\_\_\_\_ FISCAL YEAR \_\_\_\_\_

AGENCY \_\_\_\_\_

QUARTER ENDED \_\_\_\_\_

\_\_\_\_\_, 19\_\_\_\_

LINE 7.  LINE 8.  LINE 10.A.  LINE 10.B.

CHECK ONE

MEDICAL ASSISTANCE PAYMENTS TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	FEDERAL SHARE			TOTAL FEDERAL SHARE (f)	DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
		FMAP % (b)	I.H.S. FACILITY SERVICES 100% (c)	FAMILY PLANNING SERVICES 90% (d)		
1. A. INPATIENT HOSPITAL SERVICES						
B. MENTAL HEALTH FACILITY SERVICES						
C. SKILLED NURSING FACILITY SERVICES						
D. INTERMEDIATE CARE FACILITY SERVICES: (1) MENTALLY RETARDED a. PUBLIC PROVIDERS b. PRIVATE PROVIDERS						
(2) ALL OTHER						
E. PHYSICIANS' SERVICES						
F. OUTPATIENT HOSPITAL SERVICES						
G. PRESCRIBED DRUGS						
H. DENTAL SERVICES						
I. OTHER PRACTITIONERS' SERVICES						
J. CLINIC SERVICES						
K. LABORATORY AND RADIOLOGICAL SERVICES						



FORM APPROVED  
OMB NO. 0838-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

CHECK ONE	LINE 7.		LINE 8.		LINE 10.A.		LINE 10.B.		DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
	TYPE OF WAIVER WAIVER NUMBER	FISCAL YEAR	TOTAL COMPUTABLE (a)	FMAP % (b)	FEDERAL SHARE L.H.S. FACILITY SERVICES 100% (c)	FAMILY PLANNING SERVICES 90% (d)	% (e)	TOTAL FEDERAL SHARE (f)	
L. HOME HEALTH SERVICES									
M. STERILIZATIONS									
N. ABORTIONS NO.									
O. EPSDT SCREENING SERVICES									
P. RURAL HEALTH CLINIC SERVICES									
Q. HEALTH INSURANCE PAYMENTS: (1) PART B PREMIUMS (2) COINSURANCE AND DEDUCTIBLES (3) OTHER									
R. HOME AND COMMUNITY-BASED SERVICES*									
S. PERSONAL CARE SERVICES									
T. TARGETED CASE MANAGEMENT SERVICES									
U. HOSPICE BENEFITS									
V. OTHER CARE SERVICES									
W.									
Z. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 7. B, 10.A. OR 10 B. COLUMNS (g) AND (b) AS APPROPRIATE).									

\*IF STATE HAS MORE THAN ONE APPROVED HCBS WAIVER, ATTACH SCHEDULE SHOWING EXPENDITURES FOR EACH APPROVED WAIVER.

FORM HCFA-64 9a (4-88)

PAGE 2 OF 2



FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

THIRD PARTY LIABILITY COLLECTIONS  
AND COST AVOIDANCE

STATE

AGENCY

QUARTER ENDED

19

TOTAL COMPUTABLE  
(a)

FEDERAL SHARE  
(b)

A. THIRD PARTY LIABILITY COLLECTIONS

1. AMOUNT OF THIRD PARTY LIABILITY COLLECTIONS MADE IN THIS QUARTER BY SOURCE:

(a) MEDICARE TITLE XVIII

(b) OTHER COLLECTIONS: DO NOT ENTER THOSE MADE UNDER SECTIONS 1903(p) AND 1912

(1) HEALTH INSURANCE

(2) CASUALTY INSURANCE

(c) TOTAL COLLECTIONS UNDER COOPERATIVE AGREEMENTS SECTION 1903(p) AND ASSIGNMENT OF RIGHTS SECTION 1912

(1) LESS: EXCESS PAID TO INDIVIDUALS

(2) NET COLLECTIONS TO REIMBURSE STATE TITLE XIX MEDICAL PAYMENTS (ITEM 1.(c) LESS 1.(c)(1))

(3) LESS 15% INCENTIVE ACTUALLY PAID UNDER SECTION 1903(p)(1)

(4) NET FEDERAL SHARE OF COLLECTIONS REPORTABLE (ITEM 1.(c)(2) LESS 1.(c)(3))

2. TOTAL THIRD PARTY LIABILITY COLLECTIONS (ENTER COLUMNS (a) AND (b) ON SUMMARY SHEET LINE 9.A; COLUMNS (a) AND (b), COLUMN (a) TOTAL COMPUTABLE AMOUNT IS THE SUM OF ITEMS 1.(a), 1.(b)(1), 1.(b)(2) AND 1.(c)(2). COLUMN (b) FEDERAL SHARE IS THE SUM OF ITEMS 1.(a), 1.(b)(1), 1.(b)(2) AND 1.(c)(4).

B. COST AVOIDANCE

1. MEDICARE TITLE XVIII

2. HEALTH INSURANCE

3. OTHER COST AVOIDANCE

FORM HCFA-64 9a (4-88)



FORM APPROVED  
OMB NO. 09308-0087

**MEDICAID OVERPAYMENT ADJUSTMENTS**

	STATE		QUARTER ENDED		TOTAL FEDERAL SHARE (f)
	AGENCY	FY	FY	FY	
OVERPAYMENT ACTIVITY	TOTAL COMPUTABLE (a)	FY (b)	FY (c)	FY (d)	FY (e)
1. OVERPAYMENTS NOT COLLECTED OR ADJUSTED BUT REFUNDED BECAUSE OF THE EXPIRATION OF THE 60-DAY TIME LIMIT					
2. DECREASING ADJUSTMENTS TO AMOUNTS PREVIOUSLY REPORTED ON LINE 1.					
3. SUBTOTAL (LINE 1, MINUS LINE 2)					
4. PREVIOUSLY REPORTED OVERPAYMENTS TO PROVIDERS CERTIFIED THIS QUARTER AS BANKRUPT OR OUT OF BUSINESS					
5. TOTAL OVERPAYMENT ADJUSTMENTS THIS QUARTER (LINE 3, MINUS LINE 4). (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 10.C., COLUMNS (a) AND (b), RESPECTIVELY.)					





FORM APPROVED  
OMB NO. 0938-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION  
FOR THE MEDICAL ASSISTANCE PROGRAM  
EXPENDITURES IN THIS QUARTER

TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	STATE AGENCY QUARTER ENDED				TOTAL FEDERAL SHARE (f)
		90% (b)	75% (c)	50% (d)	% (e)	
1. FAMILY PLANNING						
2. DESIGN, DEVELOPMENT OR INSTALLATION OF MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS						
B. COST OF PRIVATE SECTOR CONTRACTORS						
3. SKILLED PROFESSIONAL MEDICAL PERSONNEL						
4. OPERATION OF AN APPROVED MMIS: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS						
B. COST OF PRIVATE SECTOR CONTRACTORS						
5. MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES: A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS						
B. COST OF PRIVATE SECTOR CONTRACTORS						
6. PEER REVIEW ORGANIZATIONS (PRO)						
7. OTHER FINANCIAL PARTICIPATION						
8. A. THIRD PARTY LIABILITY RECOVERY PROCEDURE—BILLING OFFSET						
J. ASSIGNMENT OF RIGHTS- BILLING OFFSET						
IMMIGRATION STATUS VERIFICATION SYSTEM COSTS (*100% FFP)						
10. NURSE AIDE TRAINING COSTS						
11. PREADMISSION SCREENING COSTS						
12. RESIDENT REVIEW ACTIVITIES COSTS						
13.						
14. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 6 COLUMNS (c) AND (d).)						

FORM HCFA-64 10, LINE 6 (4-88)



FORM APPROVED  
OMB NO. 0838-0067

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
HEALTH CARE FINANCING ADMINISTRATION

EXPENDITURES FOR STATE AND LOCAL ADMINISTRATION  
FOR MEDICAL ASSISTANCE PROGRAM  
PRIOR PERIOD ADJUSTMENTS

STATE \_\_\_\_\_ FISCAL YEAR \_\_\_\_\_

AGENCY \_\_\_\_\_

QUARTER ENDED \_\_\_\_\_, 19\_\_\_\_

CHECK ONE <input type="checkbox"/> LINE 7. <input type="checkbox"/> LINE 8. <input type="checkbox"/> LINE 10.A. <input type="checkbox"/> LINE 10.B.	TOTAL COMPUTABLE (a)	FEDERAL SHARE				TOTAL FEDERAL SHARE (f)	DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
		90% (b)	75% (c)	50% (d)	0% (e)		
TYPE OF WAIVER WAIVER NUMBER _____							
1. FAMILY PLANNING							
2. DESIGN, DEVELOPMENT OR INSTALLATION OF MMIS A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS B. COST OF PRIVATE SECTOR CONTRACTORS							
3. SKILLED PROFESSIONAL MEDICAL PERSONNEL							
4. OPERATION OF AN APPROVED MMIS A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS B. COST OF PRIVATE SECTOR CONTRACTORS							
5. MECHANIZED SYSTEMS, NOT APPROVED UNDER MMIS PROCEDURES A. COSTS OF IN-HOUSE ACTIVITIES PLUS OTHER STATE AGENCIES AND INSTITUTIONS B. COST OF PRIVATE SECTOR CONTRACTORS							
6. PEER REVIEW ORGANIZATIONS (PRO)							
7. OTHER FINANCIAL PARTICIPATION							
8. A. TPL RECOVERY PROCEDURE—BILLING OFFSET B. ASSIGNMENT OF RIGHTS—BILLING OFFSET							
9. IMMIGRATION STATUS VERIFICATION SYSTEM COSTS (100% FFP)							
10. NURSE AIDE TRAINING COSTS							
11. PREADMISSION SCREENING COSTS							
12. RESIDENT REVIEW ACTIVITIES COSTS							
13.							
14. TOTAL (ENTER COLUMNS (a) AND (f) ON SUMMARY SHEET LINE 7, 8, 10.A., OR 10.B., COLUMNS (c) AND (d)).							

**13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services**

*PURPOSE: This rule establishes a payment plan for long-term care required by the Code of Federal Regulations. The plan describes principles to be followed by Title XIX long-term care providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.*

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), MO HealthNet Division (division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for nursing facilities. Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the division as described in this regulation. Any reimbursement rate determined by the division shall be a final decision and will be implemented as set forth in the division's decision letter. The decisions of the division may be subject to review upon properly filing a complaint with the Administrative Hearing Commission (AHC). A nursing facility seeking review by the AHC must obtain a stay from the AHC to stop the division from implementing its final decision if the AHC determines the facility meets the criteria for a stay and so orders. If the facility appeals the division's decision, it is the responsibility of the nursing facility to notify any interested parties, including but not limited to, hospice providers, that the rate being received is not a final rate and is subject to change. Federal financial participation is available on expenditures for services provided within the scope of the federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement regulation shall apply only to facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this regulation shall apply only to services provided on or after January 1, 1995.

(C) The effective date of this regulation shall be January 1, 1995.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (M) multiplied by the facili-

ty's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan. Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as vocational rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of—

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in accordance with this regulation.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When a nursing facility is found not in compliance with federal requirements for participation in the Medicaid Program, sections 1919(b), (c), and (d) of the Social Security Act (42 U.S.C. 1396r), it may be terminated from the Medicaid Program or it may have imposed upon it an alternative remedy, pursuant to section 1919(h) of the Social Security Act (42 U.S.C. 1396r). In accordance with section 1919(h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken in accordance with the approved plan and timetable. It is also required that the nursing facility establish a directed plan of correction in conjunction with and acceptable to the Department of Health and Senior Services.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the division. Facilities previously certified shall retain the same provider number regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the division shall recover from that entity liabilities, sanctions, and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by

whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement and etc.

(K) A facility with certified and noncertified beds shall allocate allowable costs related to the provision of nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state regulation, be placed on a recipient's right to select providers of his/her own choice.

(N) A nursing facility's Medicaid reimbursement rate shall not be limited by its average private pay rate.

(O) The reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as food, laundry supplies, housekeeping supplies, linens, medical supplies, but not limited to, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid-eligible resident while placed in a noncertified bed in a nursing facility.

(R) All illustrations and examples provided throughout this regulation are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course



of one (1) year. The submission of the budget item by the department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components, and the pass-through expenses included in the capital cost component per diem. For facilities with allowable costs from their 1992 desk audited and/or field audited cost report as determined in this regulation that are below the facilities' January 1, 1994 reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

New Plan Rate (1-1-95)	\$49.19
January 1, 1994 Rate	\$54.32
Proposed Trend Factor	\$ 1.88
Adjusted Trend Factor	\$ 1.70
	$(\$49.19/\$54.32) * 1.88$
	$90.55\% * 1.88 = \$1.70$

The rate after the trend factor would be \$56.02 (\$54.32 + \$1.70).

(T) Rebasing.

1. The division based on its discretion shall pick at least one (1) cost report year from cost reports with fiscal years ending in 2001 or later to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. The rebased rates shall be determined in accordance with section (20).

2. The asset value will be adjusted annually based on the R. S. Means Construction Index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year(s) selected above for rebasing and as determined in paragraphs (13)(B)6. and (13)(B)7.

(U) Effective for dates of service beginning April 1, 2010, reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits shall be as follows:

1. Crossover claims for Medicare Part A inpatient skilled nursing facility benefits in which Medicare was the primary payer and the MO HealthNet Division is the payer of last resort for the coinsurance must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Part A inpatient skilled nursing facility benefits that were provided to MO HealthNet participants also having Medicare coverage; and

B. The crossover claim must contain approved coinsurance days. The amount indicated by Medicare to be the coinsurance due on the Medicare allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which Medicare is not the sole payer. These days are referred to as coinsurance days and are days twenty-one (21) through one hundred (100) of each Medicare benefit period; and

C. The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Part A inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part A plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

D. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by Medicare for the same approved coinsurance days;

2. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) inpatient skilled nursing facility benefits in which a Medicare Advantage plan was the primary payer and the MO HealthNet Division is the payer of last resort for the copay (coinsurance) must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Advantage inpatient skilled nursing facility benefits that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus); and

B. The crossover claim must be submitted as a Medicare UB-04 Part C Institutional Crossover claim through the division's online Internet billing system; and

C. The crossover claim must contain approved coinsurance days. The amount indicated by the Medicare Advantage plan to be the coinsurance due on the Medicare Advantage plan allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which the Medicare Advantage plan is not the sole payer. These days are referred to as coinsurance days and are established by each Medicare Advantage plan; and

D. The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Advantage inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

E. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by the Medicare Advantage plan for the same approved coinsurance days;

3. MO HealthNet reimbursement will be the lower of—

A. The difference between the nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days and the amount paid by either Medicare or the Medicare Advantage plan for those same coinsurance days; or

B. The coinsurance amount; and

4. Nursing facility providers may not submit a MO HealthNet fee-for-service nursing facility claim for the same dates of service on the crossover claim for Medicare Part A and Medicare Advantage inpatient skilled nursing facility benefits. If it is determined that a MO HealthNet fee-for-service nursing facility claim is submitted and payment is made, it will be subject to recoupment.

(4) Definitions.

(A) Additional beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Department of Health and Senior Services.

(B) Administration. This cost component includes the following lines from the cost report:

1. Version MSIR-1 (7-93): lines 105, 113-120, 122-140, 142-144, 147-150, 152-158 and amortization of organizational costs reported on line 106; and

2. Version MSIR-1 (3-95): lines 111-150.

(C) Age of beds. The age is determined by subtracting the initial licensing year from 1994 for prospective rates effective January 1, 1995 set during the initial 1992 rate base year calculations or the rate setting year for prospective rates effective after January 1, 1995.

(D) Allowable cost. Those costs which are allowable for allocation to the Medicaid



Program based upon the principles established in this regulation. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (HIM-15) and GAAP. Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report:

1. Version MSIR-1 (7-93): lines 62–75, 87–95, 97–103, 145–146; and
2. Version MSIR-1 (3-95): lines 71–101.

(F) Asset value. The asset value is the per bed cost of construction used in calculating a facility's capital cost component per diem utilizing the fair rental value system (FRV) as set forth in subsection (11)(D). The asset value is determined using the RS Means Building Construction Cost publication and the median, total cost of construction per bed for nursing homes from the "S.F., C.F., and % of Total Costs" table, adjusted by the total weighted average index for Missouri cities from the "City Cost Indexes" table. The initial asset value used in setting rates effective January 1, 1995 relating to the initial 1992 base year is the value for 1994 and is thirty-two thousand three hundred thirty dollars (\$32,330). The initial asset value is adjusted annually using the estimated Historical Cost Indexes from the RS Means publication for each year and is used to set the prospective rate for new facilities. The asset value in effect at the end of the rate setting period shall be used.

(G) Average private pay rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with state or federal agencies such as the Veteran's Administration or the Missouri Department of Mental Health. Bad debts, charity care, and other miscellaneous discounts are excluded in the computation of the average private pay rate.

(H) Bad debt. The difference between the amount expected to be received and the amount actually received. This amount may be written off as uncollectible after all collection efforts are exhausted. Collection efforts must be documented and an aged accounts receivable schedule should be kept. Written procedures should be maintained detailing how, when, and by whom a receivable may be written off as a bad debt.

(I) Capital. This cost component will be calculated using a fair rental value system (FRV). The fair rental value is reimbursed in lieu of the costs reported on the following lines of the cost report:

1. Version MSIR-1 (7-93): lines 106–112, except for amortization of organizational costs; and
2. Version MSIR-1 (3-95): lines 102–109.

(J) Capital asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(K) Capital asset debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(L) Ceiling. The ceiling is the maximum per diem rate for which a facility may be reimbursed for the patient care, ancillary and administration cost components, and is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is one hundred twenty percent (120%) for patient care, one hundred twenty percent (120%) for ancillary, and one hundred ten percent (110%) for administration.

(M) Certified bed. Any nursing facility or hospital based bed that is certified by the Department of Health and Senior Services to participate in the Medicaid Program.

(N) Change of ownership. A change in ownership, control, operator, or leasehold interest, for any facility certified for participation in the Medicaid Program.

(O) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, (i.e. charity care provided to meet Hill Burton Fund obligations or care provided by a religious organization for members, etc.).

(P) Contractual allowance. A contra revenue account to reduce gross charges to the amount expected to be received. Contractual allowances represent the difference between the private pay rate and a contracted rate which the facility contracted with an outside party for full payment of services rendered (i.e. Medicaid, Medicare, managed care organizations, etc.). No efforts are made to collect the difference.

(Q) Cost components. The groupings of allowable costs used to calculate a facility's per-diem rate. They are patient care, ancillary, capital, and administration. In addition, a working capital allowance is provided.

(R) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)7. of this regulation, and all worksheets supplied by the division for this

purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with this regulation and the cost report instructions and shall be prepared on forms or diskettes provided by and/or as approved by the division.

1. Cost Report version MSIR-1 (7-93) shall be used for completing cost reports with fiscal years ending prior to January 1, 1995 and shall be denoted as CR (7-93) throughout the remainder of this regulation.

2. Cost Report version MSIR-1 (3-95) shall be used for completing cost reports with fiscal years ending on or after January 1, 1995 and shall be denoted as CR (3-95) throughout the remainder of this regulation.

(S) Data bank. The data from the rate base year cost reports excluding the following facilities: hospital based, state operated, pediatric HIV, terminated or interim rate. If a facility has more than one (1) cost report with periods ending in the rate base year, the cost report covering a full twelve- (12-) month period ending in the rate base year will be used. If none of the cost reports cover a full twelve (12) months, the cost report with the latest period ending in the rate base year will be used.

1. The initial rate base year shall be 1992 and the data bank shall include cost reports with an ending date in calendar year 1992. The 1992 initial base year data shall be used to set rates effective for dates of service beginning January 1, 1995 through June 30, 2004. The 1992 initial base year data is adjusted for the HCFA Market Basket Index for 1993 of 3.9%, 1994 of 3.4%, and nine (9) months of 1995 of 3.3%, for a total adjustment of 10.6%.

2. The rate base year used for rebasing shall be 2001 and the data bank shall include cost reports with an ending date in calendar year 2001. The 2001 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2004 through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2001 rebase year data is adjusted for the CMS Market Basket Index for SFY 2002 of 3.2%, SFY 2003 of 3.4%, SFY 2004 of 2.3%, and SFY 2005 of 2.3%, for a total adjustment of 11.2%.

(T) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(U) Department of Health and Senior Services. The department of the state of Missouri responsible for the survey, certification, and licensure of nursing facilities as prescribed in Chapter 198, RSMo. Previously, the agency responsible for these duties was the Division of Aging within the Department of Social Services.



(V) Desk audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(W) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(X) Division. Unless otherwise specified, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with administration of Missouri's MO HealthNet Program.

(Y) Entity. Any natural person, corporation, business, partnership, or any other fiduciary unit.

(Z) Facility asset value. Total asset value less adjustment for age of beds.

(AA) Facility fiscal year. A facility's twelve- (12-) month fiscal reporting period covering the same twelve- (12-) month period as its federal tax year.

(BB) Facility size. The number of licensed nursing facility beds as determined from the desk audited and/or field audited cost report which has been verified with Department of Health and Senior Services records.

(CC) Fair rental value system. The methodology used to calculate the reimbursement of capital.

(DD) Field audit. An on-site audit of the nursing facility's records performed by the department or its authorized agent.

(EE) Generally accepted accounting principles (GAAP). Accounting conventions, practices, methods, rules, and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(FF) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this regulation is titled "DRI Health Care Cost—National Forecasts, HCFA Nursing Home Without Capital Market Basket." HCFA became known as the Center for Medicare and Medicaid Services (CMS) and the table name changed accordingly. The publication and publisher have also changed names but the publication still provides essentially the same information. The publication is known as the Health-Care Cost Review and it is published by Global Insight. The same or comparable index and table shall continue to be used, regardless of any changes in the name of the publication, publisher, or table.

(GG) Hospital based. Any nursing facility bed licensed and certified by the Department of Health and Senior Services, Section for Health Facilities Regulation, which is physically connected to or located in a hospital.

(HH) Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety

percent (90%) of the ancillary and administration cost component ceilings, ninety-five percent (95%) of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward.

(II) Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

(JJ) Miscellaneous discounts/other revenue deductions. A contra revenue account to reduce gross charges to the amount expected to be received. These deductions represent other miscellaneous discounts not specifically defined as a bad debt. Written policies must be maintained detailing the circumstances under which the discounts are available and must be uniformly applied.

(KK) Median. The middle value in a distribution, above and below which lie an equal number of values. The distribution for purposes of this regulation includes the per diems calculated for each facility based on or derived from the data in the data bank. The per diem for each facility is the allowable cost per day which is calculated by dividing the facility's allowable costs by the patient days. For the administration cost component, each facility's per diem included in the data bank and used to determine the median shall include the adjustment for minimum utilization set forth in subsection (7)(O) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

(LL) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities and intermediate care facilities as defined in Chapter 198, RSMo participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

(MM) Occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one of cost report, version MSIR (7-93) or (3-95), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certi-

fied portion for the same period, as determined from the desk audited and/or field audited cost report.

(NN) Patient care. This cost component includes the following lines from the cost report:

1. Version MSIR-1 (7-93): lines 45–60, 77–85; and

2. Version MSIR-1 (3-95): lines 46–70.

(OO) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(PP) Per diem. The daily rate calculated using this regulation's cost components and used in the determination of a facility's prospective and/or interim rate.

(QQ) Provider or facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX-eligible recipients.

(RR) Prospective rate. The rate determined from the rate setting cost report.

(SS) Rate setting period. The period in which a facility's prospective rate is determined. The cost report that contains the data covering this period will be used to determine the facility's prospective rate and is known as the rate setting cost report. The rate setting period for a facility is determined from applicable regulations on or after July 1, 1990.

(TT) Reimbursement rate. A prospective or interim rate.

(UU) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings;

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership, or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity directly, or through a subsidiary, operates a facility; and



3. As used in this regulation, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity—

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

C. Relative means person related by blood, adoption, or marriage to the fourth degree of consanguinity.

(VV) Replacement beds. Newly constructed beds never certified for Medicaid or previously licensed by the Department of Health and Senior Services and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(WW) Renovations/major improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(XX) Restricted funds. Funds, cash, cash equivalent, or marketable securities, including grants, gifts, taxes, and income from endowments which must only be used for a specific purpose designated by the donor.

(YY) Total facility size. Facility size plus increases minus decreases of licensed nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(ZZ) Unrestricted funds. Funds, cash, cash equivalents, or marketable securities, includ-

ing grants, gifts, taxes, and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items, and Services. All supplies, items, and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items, and services include, but are not limited to, the following:

(A) Services, items, and covered supplies required by federal or state law or regulation which must be provided by nursing facilities participating in the Title XIX program;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or regulations;

(I) All therapy services required by federal or state law or regulations;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this regulation;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this regulation;

(L) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Noncovered Supplies, Items, and Services. All supplies, items, and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare or other third-party payor. Noncovered supplies, items, and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a noncovered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items, and services for which payment is made under other Medicaid programs directly to a provider(s) other than providers of the nursing facility services; and

(C) Supplies, items, and services provided nonroutinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(P).

2. Compensation shall mean the total benefit, within the limitations set forth in this regulation, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this regulation. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual*, Part 1, Section 906.4.



(B) Covered services and supplies as defined in section (5) of this regulation.

(C) Capital Assets.

1. Capital assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include, but not be limited to, architectural fees, related legal fees, interest, and taxes during construction.

2. For purposes of this regulation, any asset or improvement costing greater than one thousand dollars (\$1,000) and having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three- (3-) year useful life.

(D) Vehicle Costs. Costs related to allowable vehicles shall be accounted for as set forth below. Allowable vehicles are vehicles which are a necessary part of the operation of a nursing facility. One (1) vehicle per sixty (60) licensed beds is allowable. For example, one (1) vehicle is allowed for a facility with zero to sixty (0–60) licensed beds, two (2) vehicles are allowed for a facility with sixty-one to one hundred twenty (61–120) licensed beds, and so forth. Costs related to vehicles that are disallowed shall also be disallowed and adjustments made accordingly.

1. Depreciation.

A. An appropriate allowance for depreciation on allowable vehicles is reported on line 139 of the cost report, version MSIR-1 (7-93) and on line 133 of CR (3-95).

B. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

C. The basis of vehicle cost at the time placed in service shall be the lower of—

(I) The book value of the provider;

(II) Fair market value at the time of acquisition; or

(III) The recognized Internal Revenue Service (IRS) tax basis.

D. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the nursing facility.

E. Historical cost will include the cost incurred to prepare the vehicle for use by the nursing facility.

F. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

2. Interest. Interest cost on vehicle debt related to allowable vehicles shall be reported on line 139 of CR (7-93) and line 134 of CR (3-95).

3. Insurance. Insurance cost related to allowable vehicles shall be reported on line 140 of CR (7-93) and line 135 of CR (3-95).

4. Rental and leases. Lease cost related to allowable vehicles shall be reported on line 139 of CR (7-93) and on line 135 of CR (3-95).

5. Personal property taxes. Personal property taxes related to allowable vehicles shall be reported on line 112 of CR (7-93) and on line 109 of CR (3-95).

6. Other miscellaneous maintenance and repairs. Other miscellaneous maintenance and repairs related to allowable vehicles shall be reported on line 139 of CR (7-93) and on line 135 of CR (3-95).

(E) Insurance.

1. Property insurance. Insurance cost on property of the nursing facility used to provide nursing facility services. Property insurance should be reported on line 109 of the cost report version MSIR-1 (7-93) and line 107 of CR (3-95).

2. Other insurance. Liability, umbrella, and other general insurance for the nursing facility should be reported on line 140 of the cost report version MSIR-1 (7-93) and line 136 of CR (3-95).

3. Workers' compensation insurance. Insurance cost for workers' compensation should be reported on the applicable workers' compensation lines on the cost report corresponding to the employee salary groupings.

(F) Interest and Borrowing Costs on Capital Asset Debt. Allowable interest and borrowing costs, as set forth below, are reimbursed as part of the capital cost component per diem detailed in subsection (11)(D).

1. Interest will be reimbursed for necessary loans for outstanding capital asset debt from the rate setting cost report at the prime rate plus two (2) percentage points, as set forth in paragraph (11)(D)3.

2. Loans (including finance charges, prepaid costs, and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the acquisition and/or renovation of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the

provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight-line basis. Borrowing costs include loan costs (that is, lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest, and discounts. Finder's fees are not allowed.

5. If loans for capital asset debt exceed the facility asset value, the interest and borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. An illustration of how allowable interest and allowable borrowing costs is calculated is detailed in paragraphs (11)(D)3. and 4.

(G) Rental and Leases.

1. Capitalized leases, as defined by GAAP, are to be reported on the books of the facility as if the facility owns the property (i.e., the building, equipment, and related expenses are recorded on the books of the facility) in accordance with subsections (7)(C), (E), (F) and (H). A facility operating its building under a capital lease shall have its capital cost component calculated using the fair rental value system.

2. Operating leases, as defined by GAAP, shall be reported on line 103 of CR (3-95). A facility operating its building under an operating lease shall have its capital cost component calculated using the fair rental value system. A facility may record the property insurance, real estate taxes and personal property taxes directly on the applicable capital lines of the cost report (i.e., lines 107, 108, and 109 of CR (3-95), respectively), and include the costs of such in calculating the pass-through expenses portion of the capital rate if it meets the following criteria:

A. If the cost of the property insurance, real estate taxes, and personal property taxes are a distinct component of a facility's operating lease for the building and the lease payment is directly affected or changed by the amount of these items; and

B. The cost of the property insurance, real estate taxes, and personal property taxes included in the lease must be documented and supported by the property insurance premium notice and tax assessment notices relating to the nursing facility.

(H) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility used to provide nursing facility services.

(I) Value of Services of Employees.

1. Except as provided for in this regulation, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually





compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost, provided that the services are not of a religious nature and are compensated. Costs of wardrobe and similar items shall not be allowable.

(J) Employee Benefits.

1. Retirement plans.

A. Contributions to IRS qualified retirement plans shall be an allowable cost.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Provider payments for unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee.

B. Amounts paid by organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost:

A. Credit life insurance (term insurance), if required as part of a mortgage loan agreement. An example, would be insurance on loans granted under certain federal programs;

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be an employee benefit and is an allowable cost. This cost should be reported on the applicable payroll lines on the cost report for the employees salary groupings; and

C. Health, disability, dental, etc., insurances for employees/owners shall be allowable costs.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable, except for costs associated with nurse aide training and competency evaluation program.

2. Costs of education and training shall include travel costs, but will not include leaves of absence or sabbaticals.

(L) Organizational Costs.

1. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to states for incorporation.

2. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

3. Where a provider is organized within a five- (5-) year period prior to its entry into the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

4. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(M) Advertising Costs. Advertising costs which are reasonable and appropriate are allowable. The costs must be a common and accepted occurrence for providing nursing facility services.

(N) Cost of Supplies and Services Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the cost report a provider shall identify related party suppliers and the type, the quantity, and costs to the related party for goods and services obtained from each such supplier.

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. The adjustment for minimum utilization is reflected in the calculation of the per diem for the administration and capital cost components. If the provider's occupancy is less than eighty-five percent (85%), the total allowable costs are

divided by the minimum utilization days rather than the facility's actual patient days. Minimum utilization days are calculated by multiplying the facility's bed days by the minimum utilization percent. Bed days are calculated by multiplying the number of beds licensed during the cost report period times the days in the cost report period. If the facility is removing the noncertified area revenues and expenses by completing a worksheet 1, bed days are calculated by multiplying the number of beds certified during the cost report period times the days in the cost report period. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this regulation. The total of central office/home office and/or management company costs, as reported on lines 129 and 130 of the cost report, version MSIR (7-93) and lines 121 and 122 of CR (3-95), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight-line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over sixty (60) months and would be reported on line 49, RN of CR (7-93) and line 51 of CR (3-95).

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, the fee assessed to nursing facilities in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Non-allowable Costs. Costs not reasonably related to nursing facility services shall not be included in a provider's costs. Non-allowable costs include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;



(C) Capital cost increases due solely to changes in ownership;

(D) Charitable contributions;

(E) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

(F) Costs such as legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(G) Directors' fees included on the cost report in excess of two hundred dollars (\$200) per month, per individual;

(H) Federal, state, or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the department and attorney's fees which are not related to the provision of nursing facility services, such as litigation related to disputes between or among owners, operators, or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Noncovered supplies, services, and items as defined in section (6);

(P) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare Provider Reimbursement Manual* Part 1, Section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owners/administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range.

2. The salary identified above will be apportioned on the basis of hours worked in the facility(ies), home office, or management company as applicable to total hours in the facility(ies), home office, or management company;

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by

priests, rabbis, ministers, or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided nonroutinely to residents for personal comfort or convenience;

(U) Salaries, wages, or fees paid to non-working officers, employees, or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

(W) Taxes or assessments for which exemptions are available;

(X) Value of services (imputed or actual) rendered by nonpaid workers or volunteers;

(Y) All costs associated with nurse aide training and competency evaluation program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;

5. Cash, trade, quantity, time, and other discounts;

6. Purchase rebates and refunds;

7. Recovery on insured loss;

8. Parking lot revenues;

9. Vending machine commissions or profits;

10. Sales from supplies to individuals other than nursing facility recipients;

11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;

12. Barber and beauty shop revenue;

13. Private room differential;

14. Medicare Part B revenues;

A. Revenues received from Part B charges through Medicare intermediaries will be offset;

B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and

17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted, and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report. The cost report (version MSIR-1 (3-95)) and cost report instructions (revised 3/95) are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerston Court, Jefferson City, MO 65109, August 1, 2008. This rule does not incorporate any subsequent amendments or additions.

1. Each provider shall adopt the same twelve- (12-) month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the division an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose. Any substitute or computer generated cost report must have prior approval by the division.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated



retain all payments which have been withheld pursuant to this provision.

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted or available upon request includes, but is not limited to, the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department, or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department, or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the division, the department, or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

8. Cost reports must be fully, clearly, and accurately completed. All required attachments must be submitted before a cost report is considered complete. If any additional information, documentation, or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the division's request, payments may be withheld from the facility until the information is submitted.

9. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

10. Exceptions. A cost report may not be required for the following if a provider requests a waiver in writing. Upon review of the provider's request, the division shall pro-

vide a written response, indicating its decision as to whether a waiver shall be granted.

A. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX recipients, relative to their fiscal year.

B. Change in provider status.

(I) Providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX recipients, relative to their fiscal year, and have less than a twelve- (12-) month cost report due to a termination, change of ownership, or being newly MO HealthNet certified.

(II) Beginning in SFY-04, the division may waive the cost report filing requirement for the cost report resulting from a change of control, ownership, or termination of participation in the MO HealthNet program if the old/terminating provider can show financial hardship in providing the cost report. The old/terminating provider must submit a written request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report.

(III) Beginning in SFY-07, the division may waive the cost report filing requirement for the cost report resulting from a change of control or ownership of participation in the MO HealthNet program if the old and new providers can provide assurances satisfactory to the division that the new providers will submit a cost report in the calendar year in which the change occurred and that the cost report will cover at least a three- (3-) month period. A written request jointly submitted by the old and new providers, indicating the new provider's fiscal year end and the dates that the cost report will cover, may provide adequate assurances.

11. Cost report requirements and withholding of funds for a change in provider status. A provider shall provide written notification to the assistant deputy director of the Institutional Reimbursement Unit of the division prior to a change of control, ownership, or termination of participation in the MO HealthNet program. If a provider does not qualify for an exception for filing a cost report as detailed above in subparagraph (10)(A)10.C., the division may withhold payments due to the provider pending receipt of the required cost report. The cost report must be prepared in accordance with this regulation with all required attachments and documentation and is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of the fully completed cost report, any payments withheld will be released, less any

amounts owed to the division such as unpaid NFRA, overpayments, etc.

A. If the division receives notification prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold a minimum of thirty thousand dollars (\$30,000) of the remaining payments from the old/terminating provider until the cost report is filed. Upon receipt of the cost report prepared in accordance with this regulation, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.

B. If the division does not receive notification prior to a change of control or ownership, the division will withhold thirty thousand dollars (\$30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement until the required cost report is filed. If the MO HealthNet payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. Upon receipt of the cost report prepared in accordance with this regulation, any payments withheld will be released to the provider identified in the current MO HealthNet participation agreement, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.

C. The division may, at its discretion, delay the withholding of funds specified in subparagraphs (10)(A)11.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the old and new provider may provide adequate assurances. The new provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars (\$30,000) if the cost report is not timely filed.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity: Certification Statement: Misrepresentation or falsification of any information contained in this cost report may



be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the state of Missouri. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were

provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering, at a minimum, the first two (2) full twelve- (12-) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings, and Statement of Cash Flow. For example, a provider begins participation in the Medicaid program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve- (12-) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve- (12-) month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Joint Use of Resources.

1. If a provider has business enterprises in addition to the nursing facility, the revenues, expenses, statistical, and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that own, control, or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year-to-year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this regulation, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

(11) Cost Components and Per Diem Calculation. The division will use the rate

setting cost report to determine the nursing facility's per diem rate for each cost component, as set forth in this section, and its prospective rate, as continued and set forth in the remaining sections of the regulation.

(A) Patient Care. Each nursing facility's patient care per diem shall be the lower of the—

1. Allowable cost per patient day for patient care as determined by the division from the rate setting cost report, including applicable trends; or

2. Per diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank.

(B) Ancillary. Each nursing facility's ancillary per diem will be the lower of the—

1. Allowable cost per patient day for ancillary as determined by the division from the rate setting cost report, including applicable trends; or

2. Per diem ceiling of one hundred twenty percent (120%) of the ancillary median determined by the division from the data bank.

(C) Administration. Each nursing facility's administration per diem shall be the lower of the—

1. Allowable cost per patient day for administration as determined by the division from the rate setting cost report, including applicable trends, and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or

2. Per diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank. The administration median shall be based on the administration per diems that have been adjusted for minimum utilization, if applicable, as described in subsection (7)(O).

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which consists of five (5) elements—rental value, return, computed interest, borrowing costs, and pass-through expenses. The calculation for each element, as well as the overall capital per diem, is detailed below in paragraphs (11)(D)1.-6.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report.

(II) Determine the number of increased licensed beds after the end of the facility's 1992 desk audited and/or field audited cost report but prior to July 1, 1994 (this is only applicable for the 1992 initial



rate base year for rates effective January 1, 1995).

(III) Determine the bed equivalency for renovations/major improvements from the date facility was originally licensed through June 30, 1994 for the 1992 initial rate base year for rates effective January 1, 1995 or through the end of the rate setting period for prospective rates effective after January 1, 1995, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost of the renovation/major improvement must be at least the asset value per bed for the year of the renovation/major improvement for each bed equivalency. For example, a renovations/major improvements done in 1994 with a cost of two hundred twenty thousand dollars (\$220,000) is equal to six (6) beds. (\$220,000/\$32,330 equals 6.80 beds rounded down to 6 beds).

(IV) Determine the number of decreased licensed beds after the end of the facility's 1992 cost report but prior to July 1, 1994 (this is only applicable for the 1992 initial rate base year for rates effective January 1, 1995).

(V) The Total Facility Size is the sum of (I), (II), and (III) less (IV).

(VI) The Total Asset Value is the total facility size times the asset value.

B. Determine the reduction for age. The age of the beds is determined by subtracting the year the beds were originally licensed from the year relative to the end of the rate setting period. The reduction for age is determined by multiplying the age of the beds by one percent (1%) up to a maximum of forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, using 1994 as the rate base year for a facility with original licensure in 1977 of sixty (60) beds and an additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1990, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1990	4	10	40
Total		130	1780

Weighted Average Age—1780/130 beds = 13.69 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1988, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1978	16	60	960
1988	6	60	360
Total		120	1320

Weighted Average Age—1320/120 = 11.00 years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of sixty (60) beds, additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1990 and a reduction of ten (10) beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1990	4	10	40
1985*	17	(10)	(170)
Total		120	1610

\* reduction of 1977 beds

Weighted Average Age—1610/120 beds = 13.41 years rounded to thirteen (13) years. This results in a reduction for age of the beds of 13%.

(IV) The age of the bed equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120) bed facility licensed in 1978 undertakes two (2) renovations: \$200,000 in 1983 and \$100,000 in 1993. The asset value per bed is \$25,250 for 1983 and \$32,039 for 1993. The bed equivalency is seven (7) beds for 1983 and three (3) beds for 1993, the reduction percentage is calculated as follows:

Licensure/Construction Year	Age	Beds	Age × Beds
1978	16	120	1920
1983	11	7	77
1993	1	3	3
Total		130	2000

Weighted Average Method—2000/130 = 15.38 years rounded to 15 years. This results in a reduction for age of beds of 15%.

C. Determine the facility asset value. The facility asset value is the total asset value set forth in subparagraph (11)(D)1.A. less the reduction for age set forth in subparagraph (11)(D)1.B.

D. Determine the rental value. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty- (40-) year life.

E. The following is an illustration of how subparagraphs (11)(D)1.A., B., C. and D. determine the rental value:

(I) Assumptions:

1992 Rate Setting Cost Report

Licensed beds	170
Bed equivalents	4
Total facility size	174 beds
Weighted average age of the beds	23 years
Asset value	\$32,330

(II) The total asset value is the product of the total facility size times the asset value;

Total facility size	174
Asset value	× \$32,330
Total asset value	\$5,625,420

(III) Facility asset value is total asset value less the reduction for age of the beds; and

Total asset value	\$5,625,420
× Age of beds	× 23%
-Reduction for age (23%)	\$1,293,847
Facility asset value	\$4,331,573

(IV) Rental value is the facility asset value multiplied by 2.5%.

Facility asset value	\$4,331,573
	× 2.5%
Rental value	\$108,289

2. Return.

A. Reduce the facility asset value by the necessary outstanding capital asset debt from the rate setting cost report, but not less than zero (0), times the rate of return. The rate of return is the yield for the thirty- (30-) year Treasury Bond as reported by the Federal Reserve Board plus two percent (2%), as follows:

(I) For the initial 1992 rate base



year for rates effective for dates of service from January 1, 1995 through June 30, 2004, the rate of return shall be set using the yield for the thirty- (30-) year Treasury Bond reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending September 2, 1994, plus two percent (2%). The yield for the week ending September 2, 1994 is 7.48% plus 2% equals a total rate of return of 9.48%.

(II) For rates effective for dates of services beginning July 1, 2004, the rate of return is detailed in sections (20) and (21).

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's 1992 desk audited and/or field audited cost report and prior to July 1, 1994, will be added to the capital asset debt from the 1992 desk audited and/or field audited cost report (this is only applicable for the 1992 initial rate base year for rates effective January 1, 1995). The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(F)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility asset value	\$4,331,573
Capital asset debt	<u>\$2,371,094</u>
	\$1,960,479
Rate of return	<u>× 9.48%</u>
Return	\$ 185,853

3. Computed interest.

A. Computed interest will be calculated by multiplying the lesser of the necessary outstanding capital asset debt from the rate setting cost report or the facility asset value as determined in subparagraph (11)(D)1.C. by the interest rate. The interest rate is the prime rate plus two percent (2%), as follows:

(I) For the initial 1992 rate base year for rates effective for dates of service from January 1, 1995 through June 30, 2004, the interest rate shall be set using the Chase Manhattan prime rate in effect on the first business day of September as published in the *Wall Street Journal*, plus two percent (2%). The prime rate effective September 1, 1994 is 7.75% plus 2% equals a total interest rate of 9.75%. For replacement beds, additional beds, and new facilities placed in service after August 31, 1995, the prime rate will be updated annually on the first business day of each September based on the Chase Manhattan prime rate plus two (2) percentage points;

(II) For rates effective for dates of services beginning July 1, 2004, the interest

rate is detailed in sections (20) and (21).

B. The following is an illustration of how computed interest is calculated:

	<b>Example A: Facility Asset Value &lt; Debt</b>	<b>Example B: Facility Asset Value &gt; Debt</b>
<i>Assumptions:</i>		
Facility asset value	\$2,000,000	\$4,331,573
Outstanding capital asset debt	\$2,500,000	\$2,371,094
Term of debt	25 years	25 years
Prime rate—September 2, 1994	7.75%	7.75%
<i>Computed interest calculation:</i>		
Facility asset value (Ex. A)	\$2,000,000	
Outstanding capital asset debt (Ex. B)		\$2,371,094
Interest rate (prime rate + 2%)	× 9.75%	× 9.75%
Computed interest	<u>\$ 195,000</u>	<u>\$ 231,182</u>

4. Borrowing costs.

A. A provider shall capitalize allowable borrowing costs and amortize them over the life of the loan on a straight-line basis.

B. If loans for capital asset debt exceed the facility asset value, the borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

C. The following is an illustration of how allowable borrowing costs are calculated, using the data from the interest calculation example detailed above in (11)(D)3.B.:

	<b>Example A</b>	<b>Example B</b>
<i>Assumptions:</i>		
Loan costs	= \$120,000	
Discount costs	= \$125,000	
Total borrowing costs	= <u>\$245,000</u>	
Facility asset value	\$2,000,000	\$4,331,573
Outstanding capital asset debt	<u>/ 2,500,000</u>	<u>/ 2,371,094</u>
Percent of borrowing costs allowed	80%	100%
Borrowing costs	× <u>\$245,000</u>	× <u>\$245,000</u>
Allowable portion to be amortized	\$196,000	\$245,000
Term of debt	<u>/ 25 years</u>	<u>/ 25 years</u>
Allowable borrowing costs	\$7,840	\$9,800

5. Pass-through expenses.

A. Add the following pass-through expenses, including applicable trends:

(I) Property insurance – line 109 of CR (7-93) and line 107 of CR (3-95);

(II) Real estate taxes – line 111 of CR (7-93) and line 108 of CR (3-95);

(III) Personal property taxes – line 112 of CR (7-93) and line 109 of CR (3-95);

6. Capital component per diem calculation. A per diem is calculated for each element detailed above in paragraph (11)(D)1.–5. which are then added together to determine the total capital cost component per diem.

A. Rental value, return and computed interest per diems. A per diem is calculated by dividing the rental value, the return and the computed interest by the computed patient days, rounded to the nearest cent. Computed patient days are equal to the total facility size (i.e., number of licensed beds plus equivalencies) determined in part (11)(D)1.A.(V) times three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's occupancy from the rate setting cost report. The following is an illustration of how this subparagraph (11)(D)6.A. is calculated:

	<b>Allowable Cost</b>	<b>Computed Patient Days*</b>	<b>Per Diem</b>
Rental value	\$108,289	56,079	\$1.93
Return	\$185,853	56,079	\$3.31
Computed interest (from Ex. B)	\$231,182	56,079	\$4.12

\* Computed patient days:

Total facility size	174
× 365 days	<u>× 365</u>
Subtotal	63,510

Greater of minimum utilization or facility occupancy	<u>× 88.30% **</u>
Computed patient days	56,079

\*\* Assumption: facility occupancy from the rate setting cost report = 88.30%

B. Borrowing costs/pass-through expenses per diems. A per diem is calculated by dividing the borrowing costs and the pass-through expenses by the greater of the minimum utilization days as determined in subsection (7)(O) or the facility's patient days from the rate setting cost report, rounded to the nearest cent. The following is an illustration of how subparagraph (11)(D)6.B. is calculated:



	<u>Allowable Cost</u>	<u>Patient Days*</u>	<u>Per Diem</u>
Borrowing costs (from Ex.B)	\$9,800	54,940	\$0.18
Pass-through expenses	\$48,142	54,940	\$0.88

\*Patient days—the greater of:

a. minimum utilization days =  $170 \times 366 \times 85\% = 52,887$

(Note: 1992 is a leap year; therefore, 366 days are used); or

b. facility patient days = 54,940 (Assumption—this is the number of actual patient days reported on rate setting cost report)

C. The capital cost component per diem is the sum of the per diems determined in subparagraphs (11)(D)6.A. and (11)(D)6.B.

Rental value	\$ 1.93
Return	\$ 3.31
Computed interest	\$ 4.12
Borrowing costs	\$ 0.18
Pass-through expenses	\$ 0.88
Total capital cost component per diem	\$10.42

(E) Working Capital Allowance. Each nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of the sum of each facility's per diem for patient care, ancillary, and administration times the interest rate set forth in (11)(D)3., rounded to the nearest cent. The following is an illustration of how this subsection (11)(E) is calculated:

Patient care	\$38.00
Ancillary	\$ 6.00
Administration	\$11.00
Total per diem	\$55.00
Divided by 12 months	<u>12</u>
	\$ 4.58
Times 1.1 months	<u>1.1</u>
	\$ 5.04
Times Interest Rate (Prime + 2%)	<u>9.75%</u>
Working capital allowance per day	\$ 0.49

(F) The following is an illustration of how subsections (11)(A)–(E) determine the total per diem rate for the cost components:

	<u>Allowable Cost</u>	<u>Cost Ceiling</u>	<u>Per Diem</u>
Patient Care	\$38.00	\$40.00	\$38.00
Ancillary	\$ 8.00	\$ 6.00	\$ 6.00
Administration	\$12.00	\$11.00	\$11.00
Capital (FRV)			\$10.42
Working capital allowance			<u>\$ 0.49</u>
Total per diem			\$65.91

(12) Reimbursement Rate Determination. A facility's reimbursement rate shall be determined by the division as described in this regulation. Any facility with an interim rate on December 31, 1994, shall be granted an interim rate effective for services on and after January 1, 1995, as prescribed in subsection (4)(HH), if applicable. A prospective rate determined from this regulation shall be retroactively effective for services beginning on the first day of the facility's second twelve- (12-) month fiscal year but not earlier than January 1, 1995, and shall replace the interim on and after January 1, 1995.

(A) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, and with a 1992 cost report on file with the division as of December 31, 1993, with a rate setting period ending in calendar year 1992 or prior shall be granted a prospective rate effective for service dates on and after January 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. The prospective rate shall be the greater of the following:

1. The per diem rate as determined in section (11); or
2. The prospective rate in effect for services rendered on January 1, 1994.

(B) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1993 shall have their prospective rate for services after December 31, 1994, based on the 1993 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the 1993 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 of 10.6% will be replaced with the 1994 and 1995 HCFA Market Basket Index of 3.4% and 3.3% respectively for a total of 6.7%; or
2. The prospective rate in effect for services rendered on January 1, 1994.

(C) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1994 shall have their prospective rate for services after

December 31, 1994, based on the 1994 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the 1994 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 of 10.6% will be replaced with the 1995 HCFA Market Basket Index of 3.3%; or
2. The prospective rate in effect for services rendered on January 1, 1994.

(D) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after December 31, 1994, but before December 1, 1995, shall have their prospective rate for services after December 31, 1994, based on the rate setting cost report ending after December 31, 1994 but before December 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the fiscal year ending after December 31, 1994 but prior to December 1, 1995, desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 will not be applied; or
2. The prospective rate in effect for services rendered on December 31, 1994.

(E) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after November 30, 1995, shall have their prospective rate based on a rate setting cost report ending after November 30, 1995. A prospective rate will be effective for services on or after the first day of the rate setting period as determined in section (11), except the desk audited and/or field audited cost report ending after November 30, 1995, will be used. The 1993, 1994, and nine (9) months of 1995 HCFA Market Basket Index will not be applied.

(F) A facility entering the MO HealthNet program after December 31, 1994, shall



receive an interim rate as defined in subsection (4)(HH) to be effective on the initial date of MO HealthNet certification. A prospective rate shall be determined in accordance with this regulation from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve- (12-) month fiscal year following the facility's initial date of MO HealthNet certification. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 will not be applied. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve- (12-) month fiscal year.

(G) A facility with a valid Medicaid participation agreement in effect after December 31, 1994, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section, 13 CSR 70-10.016, and 13 CSR 70-10.017.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments as set forth in 13 CSR 70-10.016. Global per diem rate adjustments shall be added to the specified cost component ceiling.

(B) Special Per Diem Rate Adjustments. Special per diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient care incentive. Each facility with a prospective rate on or after January 1, 1995, shall receive a per diem adjustment equal to ten percent (10%) of the facility's allowable patient care per diem subject to a maximum of one hundred thirty percent (130%) of the patient care median when added to the patient care per diem as determined in subsection (11)(A). This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Ancillary incentive. Each facility

with a prospective rate on or after January 1, 1995, and which meets one (1) of the following criteria shall receive a per diem adjustment:

A. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is below ninety percent (90%) of the ancillary median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) and ninety percent (90%) of the ancillary median. The following is an illustration of how the ancillary per diem adjustment is calculated:

120% of median	\$6.62
90% of median	\$4.97
Difference	\$1.65
1/2 the difference	<u>  .83</u>
Per diem adjustment	\$ .83

B. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is between ninety percent (90%) and one hundred twenty percent (120%) of the median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) of the median and the facility's allowable ancillary per diem. The following is an illustration of how the ancillary per diem adjustment is calculated:

90% of median	\$4.97
120% of median	\$6.62
Ancillary per diem	\$5.21
Difference	\$1.41
1/2 the difference	<u>  .71</u>
Per diem adjustment	\$ .71

3. Multiple component incentive. Each facility with a prospective rate on or after January 1, 1995, and which meets the following criteria shall receive a per diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four (4) decimal places (.5985 or .8015 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

Percent of Total Per Diem Rate	Incentive
< 60%	\$0.00
> or = 60% but < 65%	\$1.15
> or = 65% but < 70%	\$1.30
> or = 70% but < 75%	\$1.45
> or = 75% but < or 80% =	\$1.60

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (13)(B)3.A. and the following calculation is greater than seventy-five percent

(75%), rounded to four (4) decimal places (.7485 would not receive the adjustment): Medicaid days divided by the licensed nursing facility patient days from the facility's desk audited and/or field audited 1992 cost report. The adjustment is as follows:

Calculated Percentage	Incentive
< 75%	\$0.00
> or = 75% but < 80%	\$0.15
> or = 80% but < 85%	\$0.30
> or = 85% but < 90%	\$0.45
> or = 90% but < 95%	\$0.60
> or = 95%	\$0.75

4. 1967 Life Safety Code (LSC). Currently certified nursing facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their reimbursement rate. The reimbursement shall not be effective until the Department of Health and Senior Services has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational and has reviewed the cost for compliance. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years, and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The division will use a desk audited and/or field audited cost report with the latest period ending in calendar year 1992 which is on file with the division as of December 31, 1993. This adjustment will be computed based on the documented cost submitted to the division as follows:

A. Depreciation. The cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

B. Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period on a straight-line basis; and

C. The total of subparagraphs (13)(B)4.A. and B. will be divided by twelve (12) and then multiplied by the number of months covered by the 1992 cost report. This amount will be divided by the greater of actual patient days from the 1992 cost report or eighty-five percent (85%) of the licensed bed days from the 1992 cost report.

5. Any facility that had a 1967 LSC adjustment included in their December 31, 1994 reimbursement rate shall have that adjustment added to their January 1, 1995





reimbursement rate.

6. Replacement beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Department of Health and Senior Services. The facility shall provide documentation from the Department of Health and Senior Services that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (fair rental value (FRV)) prior to the replacement beds being placed in service and the capital component per diem (FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

7. Additional beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the additional beds being placed in service and the capital component per diem (FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

8. Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate, and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of

failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general, and the costs have a substantial cost effect;

B. Extraordinary circumstances, beyond the reasonable control of the nursing facility and is not a product or result of the negligence or malfeasance of the nursing facility, include:

(I) Unavoidable acts of nature are hurricane, flooding, earthquake, tornado, lightning, natural wildfire, or other natural disaster for which no one can be held responsible that are not covered by insurance and that occur in a federally declared disaster area; or

(II) Vandalism and/or civil disorder that are not covered by insurance; and

C. The rate increase shall be calculated as follows:

(I) The one- (1-) time costs (costs that will not be incurred in future fiscal years)—

(a) To determine what portion of the incurred costs will be paid, the division will use the patient occupancy days from latest available quarterly occupancy survey from the Department of Health and Senior Services for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived;

(II) For ongoing costs (costs that will be incurred in future fiscal years): Ongoing annual costs will be divided by the greater of: annualized (calculated for a twelve- (12-) month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits, will be added to the prospective rate; and

(III) For capitalized costs, a capital component per diem (FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the extraordinary circumstances and the capital component per diem (FRV) including the extraordinary circumstances.

9. Quality Assurance Incentive.

A. Each nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per diem adjustment of three dollars and twenty cents (\$3.20). The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 46 through 69 of Schedule B in the Title XIX Cost Report). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

10. High volume adjustment. Effective for dates of service July 1, 2000, a high volume adjustment shall be granted to qualifying providers. A provider must qualify each July 1, the beginning of each state fiscal year (SFY), for the high volume adjustment and the adjustment will be effective for services rendered during the SFY, July 1 through June 30. For a provider who has a high volume adjustment on June 30, but does not qualify for the high volume adjustment on July 1 of the subsequent SFY, that provider's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective rate in effect June 30.

A. Each facility with a prospective rate on or after July 1, 2000, and which meets all of the following criteria shall receive a per diem adjustment:

(I) Have on file at the division a full twelve- (12-) month cost report ending in the third calendar year prior to the state fiscal year in which the adjustment is being determined (i.e., for SFY 2001, the third prior year would be 1998, for SFY 2002, the third prior year would be 1999, etc.);

(II) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds eighty-five percent (85%) of the total patient days for all nursing facility licensed beds;

(III) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care, ancillary, and administration cost components, as set forth in paragraphs (11)(A)1.,



(11)(B)1., and (11)(C)1., exceeds the per diem ceiling for each cost component in effect at the end of the cost report period; and

(IV) State owned or operated facilities shall not be eligible for this adjustment.

B. The adjustment will be equal to ten percent (10%) of the sum of the per diem ceilings for the patient care, ancillary, and administration cost components in effect on July 1 of each year. Effective July 1, 2002, the adjustment shall not accumulate from year-to-year.

C. The division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

D. Second tier high volume adjustment. Effective for dates of service July 1, 2002, a second tier high volume adjustment shall be granted to qualifying providers.

(I) If a nursing facility qualifies for the first tier high volume adjustment, as set forth above in subparagraph (13)(B)10.A., it may qualify for the second tier adjustment if it meets the following criteria:

(a) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds ninety-three percent (93%) of the total patient days for all nursing facility licensed beds;

(b) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care cost component, as set forth in paragraph (11)(A)1., exceeds one hundred twenty percent (120%) of the per diem ceiling for the patient care cost component in effect at the end of the cost report period; and

(c) The allowable cost per patient day as determined by the division from the applicable cost report for the administration cost component, as set forth in paragraph (11)(C)1., is less than one hundred fifty percent (150%) of the per diem ceiling for the administration cost component in effect at the end of the cost report period.

(II) The second tier high volume adjustment will be calculated as a percentage, to be determined by the Department of Social Services, of the sum of the per diem ceilings for the patient care, ancillary, and administration cost components in effect on July 1 of each year.

(a) The adjustment for State Fiscal Year 2003 shall be eighteen dollars and fifty-six cents (\$18.56) per Medicaid day.

(b) The adjustment for SFY 2004 shall be nineteen dollars and seventy-one cents (\$19.71) per Medicaid day.

(III) The adjustment shall be distributed based on a quarterly amount, in addition to per diem payments, based on Medicaid days determined from the paid day report from Missouri's fiscal agent for pay cycles during the immediately preceding state fiscal year.

(IV) The state share of the second

tier high volume adjustment shall come from certified public funds. If the aggregate certified public funds are less than the state match required, the total aggregate second tier high volume adjustment will be adjusted downward accordingly.

(V) A nursing facility must qualify for the adjustment each year to receive the additional quarterly payments.

E. High volume adjustment for nursing facilities without a full twelve- (12-) month cost report. Effective for dates of service on or after January 17, 2003, the full twelve- (12-) month cost report requirement set forth in (13)(B)10.A.(I) shall include nursing facilities that have on file at the division two (2) partial year cost reports that when combined cover a full twelve- (12-) month period.

F. Medicaid hospice days to be included in determination of Medicaid occupancy. Effective for dates of service on or after January 17, 2003, the Medicaid patient days used to determine the Medicaid occupancy requirement set forth in part (13)(B)10.A.(II) shall be calculated by adding the days paid for by the Medicaid nursing facility program plus the days paid for by the Medicaid hospice program from the cost report identified in part (13)(B)10.A.(I).

G. State Fiscal Year (SFY) 2004 Ninety Percent (90%) Medicaid High Volume Grant.

(I) Effective for SFY 2004, additional one (1) time funding shall be provided to nursing facilities that qualify for the first tier high volume adjustment, as set forth above in subparagraph (13)(B)10.A., and whose Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds ninety percent (90%) of the total patient days for all nursing facility licensed beds.

(II) The SFY 2004 High Volume Grant will be calculated as a per diem adjustment based upon the funding appropriated by the general assembly and the Medicaid days incurred by the qualifying providers during SFY 2003. The adjustment for State Fiscal Year 2004 shall be two dollars and thirty-six cents (\$2.36) per Medicaid day.

(III) The adjustment shall be distributed based on a quarterly amount, in addition to per diem payments, based on Medicaid days determined from the paid days report from Missouri's fiscal agent for pay cycles during State Fiscal Year 2003.

H. High volume adjustment for nursing facilities placed in receivership.

(I) For facilities placed in receivership under Missouri law after December 31, 2001, the division shall make a determination as to whether the operator of the facility when the receivership ended (i.e., successor operator) is a related party to the facility placed in receivership. If the successor operator is

determined to be an unrelated party and the facility was receiving the high volume adjustment prior to the receivership, the facility shall continue to receive the high volume adjustment during the receivership and until the adjustment is based on the first full year cost report prepared by the successor operator.

(II) Any adjustments contingent upon the facility qualifying for the high volume adjustment shall not be granted if the facility did not qualify for the high volume adjustment except as provided in part (13)(B)10.G.(I) above.

(III) This provision only applies until the first full year cost report is available, after which the facility must qualify for the high volume adjustment each year as specified in subparagraphs (13)(B)10.A., B., and C. in order to receive it.

11. Minimum Rate Adjustment. A minimum rate adjustment shall be granted to qualifying providers, as follows:

A. Effective for dates of service beginning July 1, 2001, the minimum Medicaid reimbursement rate for nursing facility services shall be eighty-five dollars (\$85).

12. Invasive Ventilator Care Adjustment. Effective for dates of service beginning January 1, 2013, a per diem adjustment shall be granted for ventilator services provided by qualifying providers to qualifying MO HealthNet participants as set forth in 13 CSR 70-10.017.

(C) Conditions for prospective rate adjustments. The division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the division to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information shall in any way affect the division's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court order; and



4. Disallowance of federal financial participation.

(14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set as follows:

1. For out-of-state providers which provided services for Missouri Title XIX recipients, the reimbursement rate shall be the rate paid for comparable services and level of care by the state in which the provider is located. The reimbursement rate will remain in effect until—

A. Rate increases—The division receives written notification of an increase in the provider’s rate as issued by the state MO HealthNet agency in which the provider is located. The provider must also include a copy of the rate letter issued by their state detailing the rate and effective date. If the provider notifies the division within thirty (30) days of receipt of notification from their state of the per diem rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state’s rate letter. If the division does not receive written notification from the provider within thirty (30) days of the date the provider received notification from their state of the rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the first day of the month following the date the division receives notification; or

B. Rate decreases—The division receives written notification of a decrease in the provider’s rate as issued by the state Medicaid agency in which the provider is located including a copy of the rate letter issued by their state detailing the rate and effective date. The effective date of the rate decrease for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state’s rate letter.

(C) The Title XIX reimbursement rate for hospital based providers, which provide services of less than one thousand (1,000) patient days for Missouri Title XIX recipients, relative to their fiscal year, are exempt from filing a cost report as prescribed in section (10).

1. For hospital based nursing facilities that have less than one thousand (1,000) Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for patient

care, ancillary and administration, working capital allowance, and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

2. For hospital based nursing facilities with a provider agreement in effect on December 31, 1994, a prospective rate shall be set by one (1) of the following:

A. The hospital based nursing facility requests, in writing, that their prospective rate be determined from their rate setting cost report as set forth in this regulation; or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

(15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this regulation, the division may also impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulations.

(B) Overpayments due the Medicaid program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156, RSMo and 622.055, RSMo providers may seek hearing before the Administrative Hearing Commission of final decisions of the director or the division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this regulation are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the regulation at least to the extent these services are available to the general public.

(19) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this regulation.

(20) Rebasing of Nursing Facility Rates.

(A) Effective July 1, 2004, nursing facility rates shall be rebased on an annual basis. The rebased rates shall be phased in as set forth below in subsection (20)(B). Each nursing facility shall have its prospective rate recalculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation, unless otherwise noted in this section (20). The following items have been updated to reflect the rebase:

1. Nursing facility rates shall be rebased on an annual basis using the cost report year that is three (3) years prior to the effective date of the rate change. For example, for SFY 2005, the effective date of the rate change is for dates of service beginning July 1, 2004 and the cost report year used to recalculate rates shall be 2001; for SFY 2006, the effective date of the rate change is for dates of service beginning July 1, 2005 and the cost report year used to recalculate rates shall be 2002; etc.

A. A new databank shall be developed from the cost reports for each rebase year in accordance with paragraph (20)(A)1. and subsection (4)(S).

B. The costs in the databank shall be trended using the indices from the most recent publication of the Health-Care Cost Review available to the division using the “CMS Nursing Home without Capital Market Basket” table. The costs shall be trended using the second quarter indices for each year. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2005, the trends are from the First Quarter 2004 publication of the Health-Care Cost Review and include the following:

- (I) 2002:2 = 3.2%
- (II) 2003:2 = 3.4%
- (III) 2004:2 = 2.3%
- (IV) 2005:2 = 2.3%
- (V) The total trend applied to the 2001 cost report data is 11.2%.

C. The medians and ceilings shall be recalculated each year, based upon the trended costs included in the new databank that is developed each year.

D. The costs, beds, days, renovations/major improvements, loans, etc. from each facility’s cost report included in the databank shall be used to recalculate each facility’s rate. The costs reflected in each facility’s cost report shall be trended as detailed above in (20)(A)1.B.;



2. The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be updated each year based upon the RS Means Building Construction Cost Data for the year coinciding with the effective date of the rates. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the “S.F., C.F., and % of Total Costs” table and adjusting it by the total weighted average index for Missouri cities from the “City Cost Indexes” table. For SFY 2005, the asset value shall be forty-one thousand seven hundred twenty-eight dollars (\$41,728);

3. The age of the beds shall be calculated from the year coinciding with the effective date of the rates;

4. The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be updated to reflect the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%);

5. The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be updated to reflect the interest (i.e., coupon) rate for the most recent issue of thirty- (30-) year Treasury Bonds in effect on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the rate of return shall be the thirty- (30-) year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%;

6. The administration cost component per diem calculation shall not be adjusted for minimum utilization;

7. The capital cost component per diem calculation shall be adjusted for minimum utilization using the Department of Health and Senior Services’ (DHSS) Intermediate Care Facility/Skilled Nursing Facility Certificate of Need Quarterly Survey (CON Quarterly Survey) for the most recent quarter available to the division relative to the effective date of the rates. The occupancy data from the CON Quarterly Survey shall be adjusted by the division using total licensed beds rather than available beds as is used by DHSS. For SFY 2005, the minimum utilization percent for the capital component is the adjusted industry average from the October–December 2003 CON Quarterly Survey and shall be seventy-three percent (73%);

8. The high volume adjustment for SFY 2005 shall continue to be based on the 2001 cost report rather than the cost report ending in the third calendar year prior to the state fiscal year as set forth in (13)(B)10.A.(I). The remaining criteria and calculations set forth in (13)(B)10. shall continue to be applicable. Therefore, facilities receiving the high volume adjustment for SFY 2004 shall continue to receive the same high volume adjustment for the first year of the rebase (i.e., July 1, 2004–June 30, 2005); and

9. Since rates are being recalculated each year, rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)6., (13)(B)7., and (13)(B)8. are no longer allowed.

(B) The rebased rates shall be phased in, as set forth below:

1. A preliminary rebased rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in paragraphs (20)(A)1.–9.

2. The total increase resulting from the rebase each year shall be calculated as follows:

A. Each facility’s current rate as of June 30 of each year shall be compared to the preliminary rebased rate effective July 1 of the following SFY. For example, for SFY 2005, the facility’s rate as of June 30, 2004 shall be compared to the preliminary rebased rate effective July 1, 2004; for SFY 2006, the facility’s rate as of June 30, 2005 shall be compared to the preliminary rebased rate effective July 1, 2005; etc.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the current rate or the preliminary rebased rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraph (20)(B)2.B.

B. If the preliminary rebased rate is greater than the current rate, the difference between the two (2) shall represent the total increase that will be phased in by granting one-third (1/3) of the total increase each year. For SFY 2005, one-third (1/3) of the total increase shall be added to the facility’s current rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility’s prospective rate for SFY 2005.

C. If the preliminary rebased rate is less than the current rate, the facility shall continue to receive its current rate with any applicable adjustments for high volume and NFRA for the SFY.

(C) Interim rates and rates for hospital-based facilities that do not submit cost reports due to having less than one thousand (1,000) patient days for Medicaid residents shall also be recalculated and increases given each July 1 as set forth above.

(D) Effective for dates of service beginning April 1, 2005, the rebased rates for SFY 2005 shall be calculated as follows:

1. The audited 2001 cost report data shall continue to be used to develop the databank and to determine each nursing facility’s rebased rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility’s final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective April 1, 2005. The following items have been revised for the April 1, 2005 rate calculation:

A. A new databank shall be developed using the audited 2001 cost report data set forth above in paragraph (20)(D)1. for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S); and

B. The administration and capital cost components shall be adjusted for minimum utilization at eighty-five percent (85%) occupancy, rather than as set forth in paragraph (20)(A)6.–7.

(E) Prospective Rate Determination for Newly Medicaid Certified Nursing Facilities. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program and have its prospective rate set on its second full twelve- (12-) month cost report following the facility’s initial date of certification. The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility’s rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service. For example, for a rate setting period of January 1, 2004 through December 31, 2004, the facility’s initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time and rate changes that occurred after January 1, 2004 shall be calculated in accordance with the



regulation applicable to each rate change throughout the period, as follows: the facility's initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time (sections (1)-(19)); nursing facility rates were rebased effective July 1, 2004 per section (20); the rebase provisions were modified effective April 1, 2005 under subsection (20)(D); the per diem rate calculation effective for dates of service beginning July 1, 2005 are detailed in section (21); a quality improvement adjustment of three dollars and seventeen cents (\$3.17) per day was granted effective July 1, 2006 in 13 CSR 70-10.016; etc.

1. A nursing facility that did not have a prospective rate established when rates were rebased on July 1, 2004, shall have its prospective rate for dates of service beginning on or after July 1, 2004 through June 30, 2005 established on the rate setting cost report in accordance with section (20), consistent with the rest of the nursing facility industry.

2. As set forth in paragraphs (20)(B)1. and 2., a preliminary rate shall be calculated and compared to the facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, to determine the total increase. The NFRA shall not be included in the preliminary rate or the June 30, 2004 rate for comparison purposes in determining the total increase.

A. If the facility will have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the prospective rate shall be the rate for comparison purposes in determining the total increase.

B. If the facility will not have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the division will calculate a June 30, 2004 computed rate which will be used as the rate for comparison purposes in determining the total increase as follows:

(I) The rate setting cost report as determined in subsection (12)(F) shall be used.

(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the *Health-Care Cost Review* available to the division using the "CMS Nursing Home without Capital Market Basket" table. The allowable costs shall be negatively trended using the second quarter indices for each year, beginning with the index for the year relative to the end of the rate setting period back to and including the index for 2005. For example, a rate setting cost report for the

period July 1, 2006 through June 30, 2007, shall have a 2007 rate setting year. The allowable costs shall be negatively trended by the 2007 second quarter index, the 2006 second quarter index, and the 2005 second quarter index. The resulting allowable costs shall be used to determine the June 30, 2004 computed rate.

(III) The computed rate shall be calculated in accordance with sections (1)-(19) of this regulation, prior to the rebase, using the regulations applicable to calculating a June 30, 2004 rate including the cost component ceilings, interest, rate of return, etc. in effect on June 30, 2004.

3. If the preliminary rate is greater than the June 30, 2004 rate, the facility shall receive one-third (1/3) of the total increase of the preliminary rate over the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The one-third (1/3) increase shall be added to the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The NFRA in effect shall be added to that total to determine the prospective rate.

4. If the preliminary rate is less than the June 30, 2004 rate, the facility's June 30, 2004 rate plus the NFRA in effect shall become the prospective rate.

(21) Per Diem Rate Calculation Effective for Dates of Service Beginning July 1, 2005. Effective for dates of service beginning July 1, 2005, the rebase provisions set forth in section (20) shall not apply. Effective for dates of service beginning July 1, 2005, the per diem rates shall be calculated using the same principles and methodology as detailed throughout sections (1)-(19) of this regulation, except that the data indicated in this section (21) shall be used.

(A) The audited 2001 cost report data shall be used to develop the databank and to determine each nursing facility's per diem rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility's final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective July 1, 2005.

1. A new databank shall be developed using the audited 2001 cost report data set forth above in subsection (21)(A) for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S).

2. The costs in the databank shall be trended using the second quarter indices from the First Quarter 2004 publication of the

*Health-Care Cost Review* using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended for the years following the cost report year, up to and including SFY 2005. The trends applied to the 2001 cost report data include the following:

- A. 2002:2 = 3.2%
- B. 2003:2 = 3.4%
- C. 2004:2 = 2.3%
- D. 2005:2 = 2.3%

E. The total trend applied to the 2001 cost report data is 11.2%.

3. The medians and ceilings shall be recalculated, based upon the trended costs included in the new databank.

4. The costs, beds, days, renovations/major improvements, loans, etc. from each facility's cost report included in the databank shall be used to calculate each nursing facility's rate. The costs reflected in each facility's cost report shall be trended as detailed above in paragraph (21)(A)2.

(B) The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be based upon the 2004 publication of the RS Means Building Construction Cost Data. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the "S.F., C.F., and % of Total Costs" table and adjusting it by the total weighted average index for Missouri cities from the "City Cost Indexes" table. The asset value shall be forty-one thousand seven hundred twenty-seven dollars and fifty cents (\$41,727.50).

(C) The age of the beds shall be calculated from 2004.

(D) The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June 2004 plus two percent (2%). The interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%).

(E) The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be the interest (i.e., coupon) rate for the most recent issue of thirty- (30-) year Treasury Bonds in effect on the first business day of June 2004 plus two percent (2%). The rate of return shall be the thirty- (30-) year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%.

(F) The administration and capital cost components shall be adjusted for minimum utilization at eighty-five percent (85%) occupancy.

(G) The high volume adjustment shall continue to be that determined for SFY 2004. The 2001 cost report shall continue to be



used rather than the cost report ending in the third calendar year prior to the state fiscal year as set forth in part (13)(B)10.A.(I), and the remaining criteria and calculations set forth in paragraph (13)(B)10. shall continue to be that used in the SFY 2004 calculation. Therefore, facilities receiving the high volume adjustment for SFY 2004 shall continue to receive that same high volume adjustment which will be included in its rate effective for dates of service beginning July 1, 2005.

(H) Rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)6., (13)(B)7., and (13)(B)8. are no longer allowed.

1. Beginning State Fiscal Year 2016, an adjustment to the capital rate may be allowed for extraordinary circumstances as set forth in paragraph (13)(B)8. except the requirement that the occurrence is not covered by insurance does not have to be met. If a nursing facility is destroyed by an unavoidable act of nature beyond the control of the facility or vandalism and/or civil disorder the rebuilt nursing facility may apply for an adjustment to the capital component of the per diem rate, as calculated in part (13)(B)8.C.(III). The rate adjustment will be effective the date the rebuilt nursing facility is placed in service.

(I) Facility size and occupancy rate adjustment. If a facility qualifies for the facility size and occupancy rate adjustment, its facility size and occupancy rate shall be adjusted and used in the calculation of its per diem rate.

1. Qualifying criteria. A nursing facility may qualify for a facility size and occupancy adjustment if it meets all of the following criteria:

A. The facility has been operating only fifty percent (50%) of its licensed bed capacity; and

B. Every resident has been residing in a private room; and

C. The facility has been operating as such (as detailed in subparagraphs A. and B. above) from the beginning of their 2001 cost report period through the date the rate is effective as reported on the quarterly survey form, "Missouri Department of Health and Senior Services, Division of Senior Services and Regulation, ICF/SNF Certificate of Need Quarterly Survey" (form MO 886-9001(6-95)) (quarterly survey); and

D. The facility's intent for operating as such is to qualify for a Certificate of Need (CON) in accordance with section 197.318.9, RSMo 2000.

2. Calculation of adjusted facility size, adjusted occupancy rate, and adjusted per diem rate.

A. Adjusted facility size. The facility size as defined in subsection (4)(BB) and used in the determination of a facility's capital cost component under the fair rental value system set forth in subsection (11)(D) shall be

adjusted to reflect fifty percent (50%) of the licensed bed capacity.

B. Adjusted occupancy rate. The occupancy rate as defined in subsection (4)(MM) shall be adjusted to reflect fifty percent (50%) of the licensed bed capacity by adjusting the bed days used to determine the occupancy rate. The bed days shall be calculated using fifty percent (50%) of the licensed bed capacity and the adjusted occupancy rate shall be calculated by dividing the facility's total actual patient days by the adjusted bed days.

C. The adjusted facility size and the adjusted occupancy rate shall be used to determine the facility's per diem rate in accordance with the remaining provisions of this regulation.

3. The facility must notify the division in writing that it qualifies for this adjustment and provide the proper documentation, including the following:

A. A copy of the quarterly surveys from the beginning of the 2001 cost report period through the date the rate is effective; and

B. A copy of an approved CON obtained under section 197.318.9, RSMo 2000, or a written statement indicating the facility's intention of obtaining a CON under section 197.318.9, RSMo 2000, including a specific time line detailing when they plan to apply for the CON and when they plan to begin construction relative to the CON;

C. The division shall accept such written notification from facilities that qualify for this adjustment as of July 1, 2005 for up to thirty (30) days after the effective date of this amendment.

4. This adjustment shall only apply to nursing facilities with a prospective rate on July 1, 2005 and shall only be granted for the July 1, 2005 rate calculation.

5. Loss of facility size and occupancy rate adjustment and recalculation of per diem rate. If a facility's per diem rate has been set using an adjusted facility size and an adjusted occupancy rate and at least one (1) of the conditions set forth below in subparagraphs (21)(I)5.A.(I)-(IV) is met, the facility will no longer receive the adjustment to the facility size and occupancy rate in determining its per diem rate and its per diem rate shall be recalculated.

A. The conditions for losing the facility size and occupancy rate adjustment include the following:

(I) The facility ceases to operate at fifty percent (50%) of its licensed bed capacity; or

(II) The facility ceases to operate with every resident residing in a private room; or

(III) The facility does not apply for a CON under section 197.318.9, RSMo 2000

within five (5) years of receiving the adjustment; or

(IV) The facility does not begin the construction relative to the CON obtained under section 197.318.9, RSMo 2000 within five (5) years of receiving the adjustment.

B. If the facility size and occupancy rate adjustment is lost, the facility's per diem rate shall be recalculated using the unadjusted facility size as set forth in subsection (4)(BB) and the unadjusted bed days and unadjusted occupancy rate as set forth in subsection (4)(MM).

C. The facility must notify the division within thirty (30) days if it no longer qualifies for the facility size and occupancy rate adjustment as a result of meeting one (1) of the conditions listed above in subparagraph (21)(I)5.A.

(I) If the facility notifies the division of such within thirty (30) days, the effective date of the rate recalculation shall be the date that one (1) of the conditions set forth above in subparagraph (21)(I)5.A. is met. If more than one (1) of the conditions apply, the effective date shall be the earliest date. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

(II) If the facility does not notify the division within thirty (30) days, the effective date of the rate recalculation shall be the date the facility size and occupancy rate adjustment was originally granted. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

(J) The rates effective for dates of service beginning July 1, 2005 shall be determined, as set forth below:

1. A preliminary rate for July 1, 2005 shall be calculated using the same principles and methodology as detailed throughout sections (1)-(19) of this regulation and the updated items detailed above in subsections (21)(A)-(I).

2. The total increase resulting from the July 1, 2005 preliminary rate calculation shall be calculated as follows:

A. Each facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, shall be compared to the July 1, 2005 preliminary rate calculation.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the June 30, 2004 rate or the July 1, 2005 preliminary rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraphs (21)(J)2.B. and (21)(J)2.C.;



B. If the July 1, 2005 preliminary rate is greater than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, the difference between the two (2) shall represent the total increase. Effective for dates of service beginning July 1, 2005, one-third (1/3) of the total increase shall be added to the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility's prospective rate for dates of service beginning July 1, 2005;

C. If the July 1, 2005 preliminary rate is less than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, the facility's prospective rate shall be the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016 plus the high volume adjustment, if applicable, and the current NFRA.

(K) Interim rates and rates for hospital-based facilities that do not submit cost reports due to having less than one thousand (1,000) patient days for Medicaid residents shall also be recalculated and increases given as set forth above.

(L) Prospective Rate Determination for Nursing Facilities Newly Medicaid Certified after June 30, 2004. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program and have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification. The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service. For example, for a rate setting period of January 1, 2006 through December 30, 2006, the facility's initial prospective rate effective January 1, 2006 shall be set in accordance with the regulations in effect at that time and rate changes that occurred after January 1, 2006 shall be calculated in accordance with the regulation applicable to each rate change throughout the

period, as follows: the facility's initial prospective rate effective January 1, 2006 shall be set in accordance with the regulations in effect at that time, section (21) (i.e., the per diem rate calculation effective for dates of service beginning July 1, 2005 are detailed in section (21)); a quality improvement adjustment of three dollars and seventeen cents (\$3.17) per day was granted effective July 1, 2006 in paragraph (13)(A)10.; etc.

1. A nursing facility never previously certified for participation in the Medicaid program that originally enters the Medicaid program after June 30, 2004 shall have its prospective rate for dates of service beginning on or after July 1, 2005 calculated in accordance with the provisions of section (21), consistent with the rest of the nursing facility industry. The following items shall be updated annually and shall be used in determining the prospective rate, as follows:

A. Asset value. The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be adjusted annually based upon the R. S. Means Building Construction Cost Data published each year using the "Historical Cost Indexes" table. The asset value for the year relative to the end of the rate setting period shall be used;

B. Age of beds. The age of the beds shall be calculated by subtracting the year the beds were originally licensed from the year relative to the end of the rate setting period;

C. Interest rate. The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be updated annually using the prime rate reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June of each year plus two percent (2%). The interest rate in effect at the end of the rate setting period shall be used.

2. A preliminary rate at the beginning of the rate setting period shall be calculated using the same principles and methodology as detailed throughout sections (1)-(19) of this regulation and the updated items detailed in section (21).

3. The preliminary rate at the beginning of the rate setting period shall be compared to a June 30, 2004 computed rate as detailed below to determine the total increase. The NFRA shall not be included in the preliminary rate or the June 30, 2004 computed rate for comparison purposes in determining the total increase.

A. The June 30, 2004 computed rate for comparison purposes shall be calculated as follows:

(I) The rate setting cost report as determined in subsection (12)(F) shall be used;

(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the *Health-Care Cost Review* available to the division using the "CMS Nursing Home without Capital Market Basket" table. The allowable costs shall be negatively trended using the second quarter indices for each year, beginning with the index for the year relative to the end of the rate setting period back to and including the index for 2005. For example, a rate setting cost report for the period July 1, 2006 through June 30, 2007, shall have a 2007 rate setting year. The allowable costs shall be negatively trended by the 2007 second quarter index, the 2006 second quarter index, and the 2005 second quarter index. The resulting allowable costs shall be used to determine the June 30, 2004 computed rate;

(III) The computed rate shall be calculated in accordance with sections (1)-(19) of this regulation, prior to the rebase, using the regulations applicable to calculating a June 30, 2004 rate including the cost component ceilings, interest, rate of return, etc. in effect on June 30, 2004.

B. If the preliminary rate at the beginning of the rate setting period is greater than the June 30, 2004 computed rate, the facility shall receive one-third of the total increase of the preliminary rate over the June 30, 2004 computed rate. The one-third increase shall be added to the facility's June 30, 2004 computed rate. The NFRA in effect shall be added to the total and shall be the facility's prospective rate effective at the beginning of the rate setting period.

C. If the preliminary rate at the beginning of the rate setting period is less than the June 30, 2004 computed rate, the facility's June 30, 2004 computed rate plus the NFRA in effect shall become the prospective rate effective the beginning of the rate setting period.

(M) Prospective Rate Determination for Previously Medicaid Certified Nursing Facilities Reentering the Medicaid Program. As set forth in subsection (12)(G), a nursing facility that was previously certified for participation in the Medicaid Program and either voluntarily or involuntarily terminated from the Medicaid Program which then reenters the Medicaid Program shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted subsequent to the termination date but prior to reentry into the program. The prospective rate for nursing facilities that reentered the





Medicaid Program after nursing facility rates were rebased July 1, 2004 shall be calculated as follows:

1. If there is a 2001 cost report for the nursing facility, regardless of the owner/operator who completed the 2001 cost report, the prospective rate shall be based on the 2001 cost report in accordance with section (21); or

2. If there is not a 2001 cost report for the nursing facility, the prospective rate in effect when the facility terminated from the program shall be adjusted to reflect the rate changes granted through June 30, 2004 and shall be the June 30, 2004 rate to be compared to the preliminary rebased interim rate to determine the total increase, the one-third increase and the rebased prospective rate, in accordance with section (21), consistent with the rest of the nursing facility industry.

(N) Nursing facilities who qualify to have their prospective rate set in accordance with the provisions of subsection (20)(E) shall continue to receive the rate determined from subsection (20)(E) for dates of service beginning July 1, 2005.

#### APPENDIX A

##### COVERED SUPPLIES AND SERVICES PERSONAL CARE

Baby powder  
 Bedside tissues  
 Bibs, all types  
 Deodorants  
 Disposable underpads of all types  
 Gowns, hospital  
 Hair care, basic including washing, cuts, sets, brushes, combs, nonlegend shampoo  
 Lotion, soap, and oil  
 Oral hygiene including denture care, cups, cleaner, mouthwashes, toothbrushes, and paste  
 Shaves, shaving cream, and blades  
 Nail clipping and cleaning routine

##### EQUIPMENT

Arm slings  
 Basins  
 Bathing equipment  
 Bed frame equipment including trapeze bars and bedrails  
 Bed pans, all types  
 Beds, manual, electric  
 Canes, all types  
 Crutches, all types  
 Foot cradles, all types  
 Glucometers  
 Heat cradles  
 Heating pads  
 Hot pack machines  
 Hypothermia blanket  
 Mattresses, all types  
 Patient lifts, all types  
 Respiratory equipment: compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment, and related supplies, etc.

Restraints  
 Sand bags  
 Specimen container, cup or bottle  
 Urinals, male and female  
 Walkers, all types  
 Water pitchers  
 Wheelchairs, standard, geriatric, and roll-about

##### NURSING CARE/PATIENT CARE SUPPLIES

Catheter, indwelling and nonlegend supplies  
*Decubitus* ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads, and/or turning frames, heel protectors, donuts and sheepskins  
 Diabetic blood and urine testing supplies  
 Douche bags  
 Drainage sets, bags, tubes, etc.  
 Dressing trays and dressings of all types  
 Enema supplies  
 Gloves, nonsterile and sterile  
 Ice bags  
 Incontinency care including pads, diapers, and pants  
 Irrigation trays and nonlegend supplies  
 Medicine droppers  
 Medicine cups  
 Needles including, but not limited to, hypodermic, scalp, vein  
 Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel  
 Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A and D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages of all types, cottonballs, and aerosol merthiolate, tongue depressors  
 Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags  
 Suture care including trays and removal kits  
 Syringes, all sizes and types including ascepto  
 Tape for laboratory tests  
 Urinary drainage tube and bottle

##### THERAPEUTIC AGENTS AND SUPPLIES

Supplies related to internal feedings  
 I.V. therapy supplies: arm boards, needles, tubing, and other related supplies  
 Oxygen (portable or stationary), oxygen delivery systems, concentrators, and supplies  
 Special diets

*AUTHORITY: section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013.\* Emergency rule filed Dec. 21,*

*1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. Emergency amendment filed Sept. 1, 1995, effective Oct. 1, 1995, expired March 28, 1996. Amended: Filed Sept. 1, 1995, effective March 30, 1996. Amended: Filed Dec. 22, 1995, effective Aug. 30, 1996. Amended: Filed Feb. 1, 1996, effective Sept. 30, 1996. Emergency amendment filed Sept. 20, 1996, effective Oct. 1, 1996, expired March 29, 1997. Emergency amendment filed Oct. 22, 1996, effective Nov. 1, 1996, expired April 29, 1997. Emergency amendment filed Aug. 12, 1997, effective Sept. 1, 1997, expired Feb. 27, 1998. Amended: Filed Aug. 12, 1997, effective Feb. 28, 1998. Emergency amendment filed Sept. 19, 1997, effective Oct. 1, 1997, expired March 29, 1998. Amended: Filed Sept. 25, 1997, effective March 30, 1998. Amended: Filed March 2, 1998, effective Oct. 30, 1998. Amended: Filed July 15, 1998, effective Feb. 28, 1999. Emergency amendment filed Sept. 21, 1998, effective Oct. 1, 1998, expired March 29, 1999. Amended: Filed Sept. 21, 1998, effective May 30, 1999. Emergency amendment filed Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Amended: Filed Aug. 30, 1999, effective March 30, 2000. Emergency amendment filed July 18, 2000, effective July 28, 2000, expired Jan. 24, 2001. Amended: Filed June 29, 2000, effective Feb. 28, 2001. Amended: Filed Oct. 6, 2000, effective April 30, 2001. Amended: Filed Aug. 2, 2001, effective Feb. 28, 2002. Amended: Filed July 30, 2002, effective Jan. 30, 2003. Emergency amendment filed Jan. 3, 2003, effective Jan. 17, 2003, expired July 15, 2003. Amended: Filed Jan. 3, 2003, effective June 30, 2003. Emergency amendment filed Sept. 22, 2003, effective Oct. 1, 2003, terminated Oct. 29, 2003. Amended: Filed Sept. 22, 2003, effective May 30, 2004. Amended: Filed March 12, 2004, effective Sept. 30, 2004. Emergency amendment filed June 18, 2004, effective July 1, 2004, expired Dec. 15, 2004. Amended: Filed Aug. 16, 2004, effective Feb. 28, 2005. Emergency amendment filed March 21, 2005, effective April 1, 2005, expired Sept. 27, 2005. Emergency amendment filed June 20, 2005, effective July 1, 2005, expired Dec. 27, 2005. Amended: Filed March 29, 2005, effective Sept. 30, 2005. Emergency amendment filed June 15, 2006, effective July 1, 2006, expired Dec. 28, 2006. Amended: Filed May 15, 2006, effective Nov. 30, 2006. Emergency amendment filed Sept. 17, 2007, effective Oct. 1, 2007, expired March 28, 2008. Amended: Filed March 30, 2007, effective Nov. 30, 2007. Amended: Filed July 1, 2008, effective Jan. 30, 2009. Emergency amendment filed March 11, 2010, effective April 1, 2010, expired Sept. 27, 2010. Amended: Filed March 11, 2010, effective Sept. 30, 2010. Amended: Filed July 1, 2013, effective Jan.*





30, 2014. Amended: Filed Oct. 15, 2015, effective April 30, 2016.

\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.

### 13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates

*PURPOSE: This rule sets forth the global per diem adjustments to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015, and HIV nursing facility reimbursement rates, established in 13 CSR 70-10.080. The global per diem adjustments were previously included in 13 CSR 70-10.015 and 13 CSR 70-10.080.*

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), MO HealthNet Division (division), to promulgate rules and regulations.

(2) Purpose. This regulation sets forth the global per diem adjustments to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015, and Human Immunodeficiency Virus (HIV) nursing facility reimbursement rates, established in 13 CSR 70-10.080. All principles and definitions set forth in 13 CSR 70-10.015 are applicable to nursing facilities, and all principles and definitions set forth in 13 CSR 70-10.080 are applicable to HIV nursing facilities. The terms “facility” or “facilities” as used in this regulation shall apply to both nursing facilities and HIV nursing facilities.

(3) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed in 13 CSR 70-10.015, a nursing facility’s reimbursement rate may be adjusted as described in this section. Subject to the limitations prescribed in 13 CSR 70-10.080, an HIV nursing facility’s reimbursement rate may be adjusted as described in this section.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments. Global per diem rate adjustments shall be added to the specified cost component ceiling.

#### 1. FY-96 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1995, shall be granted an increase to their per diem effective October 1, 1995, of four and six-tenths percent (4.6%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2.

of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

#### 2. FY-97 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1996, shall be granted an increase to their per diem effective October 1, 1996, of three and seven-tenths percent (3.7%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

3. Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, all facilities with either an interim rate or a prospective rate shall have its per diem adjusted to include the current NFRA as an allowable cost in its reimbursement rate calculation.

4. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars and forty-five cents (\$2.45) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty-cent (50¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

5. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar and ninety-eight cents (\$1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty-cent (40¢) increase, divided by the patient days for the facilities reporting hours for that payroll category, and factored up by eight and sixty-seven hundredths percent (8.67%) to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator, and assistant administrator.

#### 6. FY-98 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1997, shall be granted an increase to their per diem effective October 1, 1997, of three

and four-tenths percent (3.4%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., and the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1995, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

#### 7. FY-99 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on October 1, 1998, shall be granted an increase to their per diem effective October 1, 1998, of two and one-tenth percent (2.1%) of the cost determined in paragraphs (11)(A)1., (11)(B)1., (11)(C)1., the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on October 1, 1998, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

#### 8. FY-2000 negotiated trend factor—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 1999, shall be granted an increase to their per diem effective July 1, 1999, of one and ninety-four hundredths percent (1.94%) of the cost determined in subsections (11)(A), (11)(B), (11)(C), the property insurance and property taxes detailed in subsection (11)(D) of 13 CSR 70-10.015 for nursing facilities and 13 CSR 70-10.080 for HIV nursing facilities, and the minimum wage adjustments detailed in paragraphs (3)(A)4. and (3)(A)5. of this regulation; or

B. Facilities that were granted a prospective rate based on paragraph (12)(A)2. of 13 CSR 70-10.015 that is in effect on July 1, 1999, shall have their increase determined by subsection (3)(S) of 13 CSR 70-10.015.

9. FY-2004 nursing facility operations adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2003, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2003, through June 30, 2004, of four dollars and thirty-two cents (\$4.32) for the cost of nursing facility operations. Effective for dates of service beginning July 1, 2004, the per diem adjustment shall be reduced to three dollars and seventy-eight cents (\$3.78); and

B. The operations adjustment shall be



added to the facility's current rate as of June 30, 2003, and is effective for payment dates after August 1, 2003.

10. FY-2007 quality improvement adjustment—

A. Facilities with either an interim rate or prospective rate in effect on July 1, 2006, shall be granted an increase to their per diem effective for dates of service beginning July 1, 2006, of three dollars and seventeen cents (\$3.17) to improve the quality of life for nursing facility residents; and

B. The quality improvement adjustment shall be added to the facility's current rate as of June 30, 2006, and is effective for dates of service beginning July 1, 2006, and after.

11. FY-2007 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning February 1, 2007, of three dollars and zero cents (\$3.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's reimbursement rate as of January 31, 2007, and is effective for dates of service beginning February 1, 2007, for payment dates after March 1, 2007.

12. FY-2008 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2007, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2007, of six dollars and zero cents (\$6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2007, and is effective for dates of service beginning July 1, 2007.

13. FY-2009 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2008, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2008, of six dollars and zero cents (\$6.00) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2008, and is effective for dates of service beginning July 1, 2008.

14. FY-2010 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2009, shall be granted an increase to their per diem rate effective for dates of service beginning July 1, 2009, of five dollars and fifty cents (\$5.50) to allow for a trend adjustment to ensure quality nursing facility services; and

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2009, and is effective for dates of service

beginning July 1, 2009.

15. FY-2012 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on October 1, 2011, shall be granted an increase to their per diem rate effective for dates of service beginning October 1, 2011, of six dollars and zero cents (\$6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of September 30, 2011, and is effective for dates of service beginning October 1, 2011; and

C. This increase is contingent upon the federal assessment rate limit increasing to six percent (6%) and is subject to approval by the Centers for Medicare and Medicaid Services.

16. FY-2013 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2012, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2012, of six dollars and zero cents (\$6.00) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2012, and is effective for dates of service beginning July 1, 2012; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

17. FY-2014 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2013, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2013, of three percent (3.0%) of their current rate, less certain fixed cost items. The fixed cost items are the per diem amounts included in the facility's current rate from the following: subsection (2)(O) of 13 CSR 70-10.110, paragraphs (11)(D)1., (11)(D)2., (11)(D)3., (11)(D)4., (13)(B)3., and (13)(B)10. of 13 CSR 70-10.015;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2013, and is effective for dates of service beginning July 1, 2013; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

18. FY-2015 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2014, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2014, of one dollar and twenty-five cents (\$1.25) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment shall be added to the facility's current rate as of June 30, 2014, and is effective for dates of service beginning July 1, 2014; and

C. This increase is contingent upon

approval by the Centers for Medicare and Medicaid Services.

19. January 1, 2016 – June 30, 2016 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on January 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning January 1, 2016, of two dollars and nine cents (\$2.09) to allow for a trend adjustment to ensure quality nursing facility services;

B. The trend adjustment will not be added to the facility's rate after June 30, 2016; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services and sufficient funding available through the Tax Amnesty Fund.

20. Continuation of FY-2016 trend adjustment and FY-2017 trend adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall continue to be granted an increase to their per diem rate effective for dates of service beginning July 1, 2016, of two dollars and nine cents (\$2.09);

B. Facilities with either an interim rate or a prospective rate in effect on July 1, 2016, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2016, of two dollars and eighty-three cents (\$2.83) to allow for a trend adjustment to ensure quality nursing facility services;

C. The trend adjustment of two dollars and eighty-three cents (\$2.83) shall be added to the facility's rate as of June 30, 2016, which includes the two dollars and nine cents (\$2.09) increase, and is effective for dates of service beginning July 1, 2016; and

D. These increases are contingent upon approval by the Centers for Medicare and Medicaid Services.

21. FY-2018 per diem adjustment—

A. Facilities with either an interim rate or a prospective rate in effect on August 1, 2017, shall be subject to a decrease in their per diem rate effective for dates of services August 1, 2017 through June 30, 2018, of five dollars and thirty-seven cents (\$5.37);

B. The per diem adjustment of five dollars and thirty-seven cents (\$5.37) shall be deducted from the facility's current rate as of July 31, 2017, and is effective for dates of service beginning August 1, 2017;

C. Effective for dates of service beginning July 1, 2018, the per diem decrease shall be reduced to four dollars and eighty-three cents (\$4.83). A per diem adjustment of fifty-four cents (\$0.54) shall be added to the facilities current rate as of June 30, 2018, which includes the five dollars and thirty-seven cents (\$5.37) decrease, and is effective for dates of service beginning July 1, 2018; and

D. This decrease is contingent upon approval by the Centers for Medicare and Medicaid Services.



AUTHORITY: sections 208.153, 208.159, and 208.201, RSMo 2016.\* Original rule filed July 1, 2008, effective Jan. 30, 2009. Emergency rule filed Oct. 3, 2008, effective Oct. 13, 2008, expired April 10, 2009. Emergency amendment filed Nov. 9, 2009, effective Nov. 19, 2009, expired Jan. 30, 2010. Amended: Filed July 1, 2009, effective Jan. 30, 2010. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Dec. 30, 2011. Amended: Filed June 20, 2012, effective Jan. 30, 2013. Amended: Filed Oct. 30, 2013, effective May 30, 2014. Amended: Filed July 15, 2014, effective Jan. 30, 2015. Amended: Filed Nov. 16, 2015, effective May 30, 2016. Amended: Filed May 16, 2016, effective Nov. 30, 2016. Emergency amendment filed July 21, 2017, effective Aug. 1, 2017, expired Feb. 22, 2018. Amended: Filed July 21, 2017, effective Jan. 30, 2018.

\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.

13 CSR 70-10.017 Nursing Facility Invasive Ventilator Program

PURPOSE: This rule sets forth the requirements for participation in the MO HealthNet Invasive Ventilator Program and the per diem add-on amounts to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015 and 13 CSR 70-10.016. The services provided under the Invasive Ventilator Program are in addition to the nursing facility services already provided by the facility and as such are subject to all policies, rules, regulations, and provider agreements applicable to providing nursing facility services to MO HealthNet participants.

(1) The Invasive Ventilator Program is limited to—

(A) Nursing facilities licensed by the Department of Health and Senior Services (DHSS) and certified for participation in the MO HealthNet program and enrolled in the MO HealthNet Invasive Ventilator Program; and

(B) Services provided to adult MO HealthNet participants who are dependent on an invasive ventilator as a means of life support. An invasive ventilator generates breath delivered to the participant through an artificial airway positioned in the participant’s trachea.

(2) Reimbursement for Invasive Ventilator Care. Providers approved for participation in the Invasive Ventilator Program will receive payment in the form of a per diem add-on to their reimbursement rate established in accordance with 13 CSR 70-10.015. The per diem add-on amount will be one hundred fifty dollars (\$150.00) will be paid for MO HealthNet

participants who are dependent on a ventilator full time as a means of life support.

(3) Provider Requirements for Participation in the Invasive Ventilator Program.

(A) Nursing facilities seeking to participate in the Invasive Ventilator Program must submit the following information to Missouri Medicaid Audit and Compliance (MMAC), Provider Enrollment Unit:

1. A completed Invasive Ventilator Program Provider application; and

2. Any other information or documentation requested by MMAC to assist in determining enrollment status.

(B) MMAC may enter into agreements with facilities for the participation in the MO HealthNet Invasive Ventilator Program through the provider enrollment process only if the provider agrees to the following terms:

1. The provider must maintain and provide documentation demonstrating—

A. Medicaid (Title XIX) Certification;

B. The provider has the capacity and capability to provide invasive ventilator medical care as documented by DHSS, MO HealthNet Division (MHD), and MMAC records;

C. Adherence to regulatory requirements established by DHSS, MHD, and MMAC;

D. The medical condition of the participant to verify they meet the criteria for participation in this program; and

E. The provider has the following written agreements:

(I) A written agreement with an enrolled MO HealthNet Durable Medical Equipment (DME) provider which must include a service contract for invasive ventilator equipment. DME providers will bill MO HealthNet for the necessary ventilator;

(II) A written agreement with a local emergency transportation provider;

(III) A written agreement with a local hospital capable of providing the necessary care for invasive ventilator-dependent participants, when appropriate;

(IV) Presence of written emergency procedures including but not limited to the following:

(a) Procedures to care for and transport invasive ventilator-dependent participants in the event of an emergency evacuation;

(b) Procedures to care for invasive ventilator-dependent participants in the event of power failure; and

(c) Procedures to care for invasive ventilator-dependent participants in the event of equipment failure;

2. Individuals qualifying for participation in the Invasive Ventilator Program must be placed in contiguous rooms; and

3. In addition to the covered items and services included in the reimbursement rate

set forth in 13 CSR 70-10.015—

A. The nursing facility must purchase one (1) Ambu bag per invasive ventilator dependent participant and place it in a designated location readily accessible at the bedside to ensure access in the event of an emergency;

B. The provider must ensure the necessary equipment to accommodate the needs of the invasive ventilator-dependent participants is provided by the DME provider. The equipment and supplies covered under the MO HealthNet DME program will be payable directly to the DME provider;

C. Proper invasive ventilator and tracheostomy supplies and equipment are provided to the participant;

D. Each invasive ventilator is equipped with an alarm on both the pressure valve and the volume valve; and

E. Each invasive ventilator is equipped with internal batteries to provide a short term back-up system in case of a total loss of power, and the battery must be checked as recommended by the manufacturer.

(C) Termination of Participation in Invasive Ventilator Program.

1. Providers desiring to discontinue providing invasive ventilator services shall notify MMAC Provider Enrollment Unit in writing, at least sixty (60) days prior to the date of termination. Payment for invasive ventilator participants already residing in facilities who wish to discontinue providing invasive ventilator services will remain at the previous invasive ventilator rate as long as the participant meets the invasive ventilator criteria and as long as all related criteria are met by the provider or the participant is discharged.

(4) Participant Eligibility for Participation in Invasive Ventilator Program.

(A) Pre-certification must be obtained through MO HealthNet in order to receive payment under the Invasive Ventilator Program. The pre-certification must be initiated by an authorized medical assistance provider who has evaluated the medical needs of the individual. Authorized providers include physicians, advanced practice nurses, respiratory therapists, hospitals, and nursing facilities.

1. The pre-certification application will be available by contacting the Clinical Services Unit/Invasive Ventilator Program.

2. The pre-certification period will be approved for the duration of the physician’s prescription for invasive ventilation. If the invasive ventilator is used for weaning purposes, a pre-certification must be completed every ninety (90) days to ensure individuals still meet the requirements for participation in this program. An approved pre-certification request does not guarantee payment. The provider must verify participant eligibility on the date of service using the Interactive Voice Response (IVR) System at (573) 635-8908 or by logging



onto the MO HealthNet Internet Web portal at [www.emomed.com](http://www.emomed.com).

(B) Accessibility to Records. The provider must make accessible to MHD, MMAC, and/or DHSS all provider, participant, and other records necessary to determine that the needs of the participant are being met and to determine the appropriateness of invasive ventilator services.

(C) In the event that it is determined through the pre-certification process that the participant is no longer in need of or receiving invasive ventilator services, MHD shall discontinue the add-on per diem authorized by this regulation for the participant and reduce the rate of payment to the provider to the provider's standard MO HealthNet per diem rate established under 13 CSR 70-10.015.

#### (5) Cost Reporting Requirements.

(A) Providers will be required to separately identify the invasive ventilator-dependent patient days regardless of payer source that relate to dates of service within the cost reporting time period by completing a supplemental schedule as provided by MHD.

(B) Due to the complex record-keeping requirements needed to identify the specific cost of this program, MHD will remove the cost as a revenue offset determined as follows. The days from each category identified above will be multiplied by the related Invasive Ventilator add-on amount and offset against the expenses. This will ensure the additional cost of caring for these participants will be removed from the allowable cost in determining the prospective reimbursement rate. The offset will be allocated among the cost components as follows: Patient Care—sixty percent (60%), Ancillary—thirty percent (30%), and Administrative—five percent (5%). The remaining five percent (5%) will not be offset because the capital costs are easily identified and will be removed as non-allowable.

*AUTHORITY: section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2012.\* Original rule filed April 1, 2013, effective Oct. 30, 2013.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.*

### 13 CSR 70-10.030 Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services

*PURPOSE: This rule establishes a payment plan for nonstate-operated intermediate care facility for individuals with intellectual disabilities services. The plan describes principles to be followed by Title XIX intermediate care facility for individuals with intellectual disabilities providers in making financial*

*reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.*

(1) Objectives. This rule establishes a payment plan for nonstate-operated intermediate care facility for individuals with intellectual disabilities (ICF/IID) services.

#### (2) General Principles.

(A) The MO HealthNet program shall reimburse qualified providers of ICF/IID services based solely on the individual MO HealthNet participant's days of care (within benefit limitations) multiplied by the facility's Title XIX per diem rate less any payments made by participants.

(B) Effective November 1, 1986, the Title XIX per diem rate for all ICF/IID facilities participating on or after October 31, 1986, shall be the lower of—

1. The average private pay charge;
2. The Medicare per diem rate, if applicable;

3. The rate paid to a facility on October 31, 1986, as adjusted by updating its base year to its 1985 fiscal year. Facilities which do not have a full twelve- (12-) month 1985 fiscal year shall not have their base years updated to their 1985 fiscal years. Changes in ownership, management, control, operation, leasehold interests by whatever form for any facility previously certified for participation in the MO HealthNet program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement; and

4. However, any provider who does not have a rate on October 31, 1986, and whose facility meets the definition in subsection (3)(J) of this rule, will be exempt from paragraph (2)(B)3., and the rate shall be determined in accordance with applicable provisions of this rule.

(C) This plan has an effective date of November 1, 1986, at which time prospective per diem rates shall be calculated for the remainder of the state's FY-87 and future fiscal years. Per diem rates established by updating facilities' base years to FY-85 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

(D) The Title XIX per diem rates as determined by this plan shall apply only to services furnished on or after November 1, 1986.

#### (3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the MO HealthNet program based upon the principles established in this rule. The allowability of cost areas, not specifically addressed in this rule, will be based upon criteria of the *Medi-*

*care Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Average private pay charge. The average private pay charge is the usual and customary charge for non-MO HealthNet patients determined by dividing total non-MO HealthNet days of care into total revenue collected for the same service that is included in the MO HealthNet per diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

(C) Committee. The advisory committee defined in subsection (6)(A) of this rule.

(D) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(E) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(F) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(G) Effective date.

1. The plan effective date shall be November 1, 1986.

2. The effective date for rate adjustments granted in accordance with section (6) of this rule shall be for dates of service beginning the first day of the month following the director's, or his/her designee's, final determination on the rate.

(H) ICF/IID. Nonstate-operated facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

(I) Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement.

(J) New construction. Newly built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

(K) New owners. Original owners of new construction.

(L) Providers. A provider under the Prospective Reimbursement Plan is a nonstate-operated ICF/IID facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for



individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

(M) Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

(N) Related parties. Parties are related when—

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons has an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity;

C. Ownership or controlling interest is when a person or corporation(s)—

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an

entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. Relative means persons related by blood or marriage to the fourth degree of consanguinity; and

E. Entity means any person, corporation, partnership, or association.

(O) Rural. Those counties which are not defined as urban.

(P) Urban. The urban counties are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.

(4) Prospective Reimbursement Rate Computation.

(A) Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program.

1. ICF/IID facilities.

A. Except in accordance with other provisions of this rule, the MO HealthNet program shall reimburse providers of these LTC services based on the individual MO HealthNet-participant days of care multiplied by the Title XIX prospective per diem rate less any payments collected from participants. The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per diem rate. Facilities with less than a full twelve- (12-) month 1985 fiscal year will not have their base year rates updated.

B. For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1987, shall be added to each facility's rate.

C. For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1988, shall be added to each facility's rate.

D. For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent

(1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1990, shall be added to each facility's rate.

E. FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents (\$6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents (\$131.93).

F. State FY-99 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents (\$4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents (\$148.99).

G. State FY-2000 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents (\$4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents (\$154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

H. State FY-2001 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents (\$4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents (\$160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

I. State FY-2007 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2006.

J. State FY-2008 trend factor. Effective for dates of service beginning July 1,



2007, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2007.

K. State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008.

L. State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four- (4-) quarter moving average).

M. State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid to nonstate-operated ICF/IID facilities on September 30, 2011.

N. State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on December 31, 2013.

O. State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

P. State FY-2017 trend factor. Effective for dates of service beginning September 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2016.

Q. State FY-2018 per diem adjustment. Effective for dates of service beginning September 1, 2017, all nonstate-operated

ICF/IID facilities shall be subject to a decrease to their per diem rates of two and eighty-two hundredths percent (2.82%). This adjustment is equal to two and eighty-two hundredths percent (2.82%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2017.

2. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

B. In accordance with subsection (6)(B) of this rule, a newly constructed facility's initial reimbursement rate may be reduced if the facility's actual allowable per diem cost for its first twelve (12) months of operation is less than its initial rate;

C. When a facility's MO HealthNet reimbursement rate is higher than either its private pay rate or its Medicare rate, the MO HealthNet rate will be reduced in accordance with subsection (2)(B) of this rule;

D. When the provider can show that it incurred higher cost due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, the request must have a substantial cost effect. These circumstances include, but are not limited to:

(I) Acts of nature, such as fire, earthquakes, and flood, that are not covered by insurance;

(II) Vandalism, civil disorder, or both; or

(III) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system;

E. When an adjustment to a facility's rate is made in accordance with the provisions of section (6) of this rule; or

F. When an adjustment is based on an Administrative Hearing Commission or court decision.

(B) In the case of newly constructed non-

state-operated ICF/IID facilities entering the MO HealthNet program after October 31, 1986, and for which no rate has previously been set, the director or his/her designee may set an initial rate for the facility as in his/her discretion s/he deems appropriate. The initial rate shall be subject to review by the advisory committee under the provisions of section (6) of this rule.

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinence care, tray service, and enemas;

2. Items which are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, non-depreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry which is a noncovered service;

9. All general personal care services which are furnished routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent



necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

11. Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. Temporary leave of absence days must be specifically provided for in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

(6) Rate Determination. All nonstate-operated ICF/IID providers of LTC services under the MO HealthNet program who desire to have their rates changed or established must apply to the MO HealthNet Division. The department may request the participation of the Department of Mental Health in the analysis for rate determination. The procedure and conditions for rate reconsideration are as follows:

(A) Advisory Committee. The director, Department of Social Services, shall appoint an advisory committee to review and make recommendations pursuant to provider requests for rate determination. The director may accept, reject, or modify the advisory committee's recommendations.

1. Membership. The advisory committee shall be composed of four (4) members representative of the nursing home industry in Missouri, three (3) members from the Department

of Social Services, and two (2) members which may include, but are not limited to, a consumer representative, an accountant or economist, or a representative of the legal profession. Members shall be appointed for terms of twelve (12) months. The director shall select a chairman from the membership who shall serve at the director's discretion.

2. Procedures.

A. The committee may hold meetings when five (5) or more members are present and may make recommendations to the department in instances where a simple majority of those present and voting concur.

B. The committee shall meet no less than one (1) time each quarter, and members shall be reimbursed for expenses.

C. The MO HealthNet Division will summarize each case and, if requested by the advisory committee, make recommendations. The advisory committee may request additional documentation as well as require the facility to submit to a comprehensive operational review to determine if there exists an efficient and economical delivery of patient services. The review will be made at the discretion of the committee and may be performed by it or its designee. The findings from a review may be used to determine the per diem rate for the facility. Failure to submit requested documentation shall be grounds for denial of the request.

D. The committee, at its discretion, may issue its recommendation based on written documentation or may request further justification from the provider sending the request.

E. The advisory committee shall have ninety (90) days from the receipt of each complete request, provided the request is on behalf of a facility which has executed a valid Title XIX participation agreement, or the receipt of any additional documentation to submit its recommendations in writing to the director. If the committee is unable to make a recommendation within the specified time limit, the director or his/her designee, if the committee establishes good cause, may grant a reasonable extension.

F. Final determination on rate adjustment. The director's, or his/her designee's, final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the committee's recommendation.

G. The director's, or his/her designee's, final determination on the advisory committee's recommendation shall become effective on the first day of the month in which the request was made, providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective the first day of the following month;

(B) In the case of new construction where a valid Title XIX participation agreement has been executed, a request for a rate must be

submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until an initial per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of newly built facility or part of the facility which is less than two (2) years of age and enters the Title XIX Program on or after November 1, 1986, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for new construction. Owners of new construction which have an approved CON are certified for participation and which have a valid Title XIX participation agreement shall submit a budget in accordance with the principles of section (7) of this rule and other documentation as the committee may request.

2. The establishment of the permanent rate for all new construction facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for new construction facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the first day of the second full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate





increase based on review or audit of the cost report and actual operating costs;

(C) In the case of existing facilities not previously certified to participate in the Title XIX program, a request for a per diem reimbursement rate must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. Until the time as a per diem rate is established, the MO HealthNet Division shall grant a tentative per diem rate for that period. In no case may a facility receive a per diem reimbursement rate greater than the class ceiling in effect on March 1, 1990, adjusted by the negotiated trend factor.

1. In the case of a facility described in subsection (6)(C) of this rule and entering the Title XIX program on or after March 1, 1990, a reimbursement rate shall be assigned based on the projected estimated operating costs. Advice of the advisory committee will be obtained for all initial rate determination requests for first full facility's fiscal year.

2. The establishment of the permanent rate for all existing facility providers shall be based on the second full facility fiscal year cost report prepared in accordance with the principles of section (7) of this rule. This cost report shall be submitted within ninety (90) days of the close of their second full facility fiscal year. This cost report shall be based on actual operating costs. No request for an extension of this ninety- (90-) day filing requirement will be considered. Any new construction facility provider which fails to timely submit the cost report may be subject to sanction under this rule and 13 CSR 70-3.030.

3. Prior to establishment of a permanent rate for existing facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

4. The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and each facility's actual allowable per diem cost will be determined. The cost report shall not be submitted to the advisory committee for review. If a facility's actual allowable per diem cost is less than its initial per diem reimbursement rate, the facility's rate will be reduced to its actual allowable per diem cost. This reduction will be effective on the second day of the first full facility fiscal year.

5. If a facility's actual allowable per diem cost is higher than its initial per diem reimbursement rate, the facility's rate will not be adjusted; a facility shall not receive a rate increase based on review or audit of the cost

report and actual operating costs;

(D) Rate Reconsideration.

1. The committee may review the following conditions for rate reconsideration:

A. Those costs directly related to a change in a facility's case mix; and

B. Requests for rate reconsideration which the director, in his/her discretion, may refer to the committee due to extraordinary circumstances contained in the request and as defined in subparagraph (4)(A)2.D. of this rule.

2. The request for an adjustment must be submitted in writing to the MO HealthNet Division and must specifically and clearly identify the issue and the total dollar amount involved. The total dollar amount must be supported by complete, accurate, and documented records satisfactory to the single state agency. The facility must demonstrate that the adjustment is necessary, proper, and consistent with efficient and economical delivery of covered patient care services.

3. However, for state fiscal years after Fiscal Year 1987, in no case may a facility receive a per diem reimbursement rate higher than the class ceiling for that facility in effect on June 30 of the preceding fiscal year adjusted by the negotiated trend factor.

4. The following will not be subject to review:

A. The negotiated trend factor;

B. The use of prospective reimbursement rate; and

C. The cost base for the June 30 per diem rate except as specified in this rule;

(E) Rate Adjustments. The department may alter a facility's per diem rate based on—

1. Court decisions;

2. Administrative Hearing Commission decisions;

3. Determination through desk audits, field audits, and other means, which establishes misrepresentations in or the inclusion of unallowable costs in the cost report used to establish the per diem rate. In these cases, the adjustment shall be applied retroactively; or

4. Adjustments determined by the department without the advice of the rate advisory committee.

A. Prospective payment adjustment (PPA). A FY-92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

(I) For providers which qualify, the PPA shall be the lesser of—

(a) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFI-IDC) on October 1, 1991 ( $FPGF \times PPD \times$

$PPAF \times ICFI-IDC$ ). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22%  $\times$  114,244  $\times$  24.5%  $\times$  \$156.01 = \$140,659; or

(b) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

(II) FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

(III) ICFI-IDC—is one hundred fifty-six dollars and one cent (\$156.01) on October 1, 1991.

(IV) PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

(V) PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year;

5. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents (\$8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF/IID facilities; or

6. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents (\$1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents (\$118.14) for all nonstate-operated ICF/IID facilities; and

(F) Rate determination shall be based on a determination of reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care





provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined by the advisory committee with the consent of the director.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the services are actually performed and are necessary services.

2. Compensation shall mean the total benefit, within the limitations set forth in this rule, by the owner of the services s/he renders to the facility including direct payments for managerial, administrative, professional, and other services, amounts paid by the provider for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable institutions or it may be determined by other appropriate means such as the *Medicare and Medicaid Provider Reimbursement Manual* (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings, and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

- A. The book value of the provider;
- B. Fair market value at the time of acquisition;
- C. The recognized Internal Revenue Service (IRS) tax basis; and
- D. In the case of the change in own-

ership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars (\$500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph (7)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in

excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as Certificate of Need (CON).

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs, and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims, and necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners, and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.



8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (7)(C) of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection (7)(C) of this rule shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest, and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees, and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings, and equipment are allowable cost areas provided that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties which is subject to other provisions of this rule, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18,

1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program, shall be a nonallowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state, or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bond, property transfer, issuance of transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which are not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment Federal Insurance Contributions Act (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations, shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the

organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost area; provided, that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance which are not considered an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area—

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement plans.

A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners, and proprietors of the provider shall be allowable cost areas. Interest income from funded pensions or retirement plans shall be excluded from consideration in determining the allowable cost area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred compensation plans.

A. Contributions for the benefit of



employees, excluding stockholders, partners, and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items.

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders, and fees paid to states of incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

6. For change in ownership after July 18, 1984, allowable amortization will be lim-

ited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs which are reasonable, appropriate, and helpful in developing, maintaining, and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods, and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods, or services obtained elsewhere. A provider shall identify suppliers related to it in the uniform cost report and the type-quantity and costs of facilities, goods, and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/IID is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of a Title XIX participant. Utilization review costs incurred for Title XVIII and Title XIX must be apportioned on the basis of reimbursable participant days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%), the following cost centers will be calculated as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Nonreimbursable Costs.

1. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators, or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment

has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time, and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than participants; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this rule. Failure to separately account for any of the revenues specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided that interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in paragraph (7)(R)3. of this rule shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. Restricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to rerestrict restricted funds designated by the donor for paying operating costs, the funds will not be offset from total allowable expenses.

B. Unrestricted funds as used in this rule mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, that are given to a provider without restriction by the donor as to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this rule are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local, or local-to-local provider. These funds are not considered a



grant or gift for reimbursement purposes, so having no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. Provider's allowable cost areas shall be apportioned between MO HealthNet program participant residents and other patients so that the share borne by the MO HealthNet program is based upon actual services received by program participants.

2. To accomplish this apportionment, the ratio of participant residents' charges to total patient charges for the service of each ancillary department may be applied to the cost of this department. To this shall be added the cost of routine services for MO HealthNet program participant residents determined on the basis of a separate average cost per diem for general routine care areas or at the option of the provider on the basis of overall routine care area.

3. So that its charges may be allowable for use in apportioning costs under the program, each provider shall have an established charge structure which is applied uniformly to each patient as services are furnished to the patient and which is reasonable and consistently related to the cost of providing these services.

4. Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

5. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this rule, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

6. ICF/IID facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

7. In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to per-

sons not covered under the MO HealthNet program.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall not exceed twelve percent (12%).

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principle, and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to insure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the MO HealthNet program on the basis of the provider's MO HealthNet program reimbursable participant resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(8) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve-(12-) month fiscal period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed cost report shall be submitted by each provider the first day of the sixth month following the close of the fiscal period.

2. Unless adequate and current documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released

to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated, retain all payments which have been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by \_\_\_\_\_

(Provider's name(s) and number(s))

for the cost report period beginning, \_\_\_\_\_, 20\_\_\_\_ and ending \_\_\_\_\_, 20\_\_\_\_, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature) \_\_\_\_\_ (Title) \_\_\_\_\_ (Date) \_\_\_\_\_

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit



review and audit of provider’s cost reports. Failure to do so may lead to sanctions stated in section (8) of this rule or other sanctions available in section (9) of this rule.

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(E) Audits.

1. Cost reports shall be based upon the provider’s financial and statistical records which must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve- (12-) month cost reports for new construction facilities required to be submitted under section (4) of this rule may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars (\$200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

(9) Sanctions and Overpayments.

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(10) Exceptions.

(A) For those MO HealthNet-eligible participant-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, MO HealthNet reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided services of fewer than one thousand (1,000) patient days for Missouri Title XIX participants, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provide services of one thousand (1,000) or more patient days for Missouri Title XIX participants, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in sections (4) and (6) of this rule.

(11) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, MO HealthNet will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children’s Service. Procedures for remitting third-party payments are provided in the MO HealthNet program provider manuals.

(12) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(13) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.

(14) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this rule.

**APPENDIX A  
Routine Covered  
Medical Supplies and Services**

- ABD Pads
- A & D Ointment
- Adhesive Tape
- Aerosol Inhalators, Self-Contained
- Aerosol, Other Types
- Air Mattresses
- Air P.R. Mattresses
- Airway Oral
- Alcohol
- Alcohol Plasters
- Alcohol Sponges
- Antacids, Nonlegend
- Applicators, Cotton-Tipped
- Applicators, Swab-Eez
- Aquamatic K Pads (water-heated pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages (elastic or cohesive)
- Band-aids
- Basins
- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpan, Fracture
- Bedpan, Regular
- Bedside Tissues
- Benzoin
- Bibs
- Bottle, Specimen
- Canes
- Cannula Nasal
- Catheter Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Composite Pads
- Cotton Balls
- Crutches
- Customized Crutches, Canes, and Wheelchairs
- Decubitus Ulcer Pads
- Deodorants
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets



Drainage Tubes  
 Dressing Tray  
 Dressings (all)  
 Drugs, Stock (excluding Insulin)  
 Enema Can  
 Enema Soap  
 Enema Supplies  
 Enema Unit  
 Enemas  
 Equipment and Supplies for Diabetic  
   Urine Testing  
 Eye Pads  
 Feeding Tubes  
 Female Urinal  
 Flotation Mattress or Biowave  
   Mattress  
 Flotation Pads, Turning  
   Frames, or both  
 Folding Foot Cradle  
 Gastric Feeding Unit  
 Gauze Sponges  
 Gloves, Unsterile and Sterile  
 Gowns, Hospital  
 Green Soap  
 Hand-Feeding  
 Heat Cradle  
 Heating Pads  
 Heel Protector  
 Hot Pack Machine  
 Ice Bags  
 Incontinency Care  
 Incontinency Pads and Pants  
 Infusion Arm Boards  
 Inhalation Therapy Supplies  
 Intermittent Positive Pressure  
   Breathing Machine (IPPB)  
 Invalid Ring  
 Irrigation Bulbs  
 Irrigation Trays  
 I.V. Trays  
 Jelly, Lubricating  
 Laxatives, Nonlegend  
 Lines, Extra  
 Lotion, Soap, and Oil  
 Male Urinal  
 Massages (by nurses)  
 Medical Social Services  
 Medicine Cups  
 Medicine Dropper  
 Merthiolate Aerosol  
 Mouthwashes  
 Nasal Cannula  
 Nasal Catheter  
 Nasal Catheter, Insertion and Tube  
 Nasal Gastric Tubes  
 Nasal Tube Feeding  
 Nebulizer and Replacement Kit  
 Needles (hypodermic, scalp, vein)  
 Needles (various sizes)  
 Nonallergic Tape  
 Nursing Services (all) regardless of  
   level including the administration of  
   oxygen and restorative nursing care  
 Nursing Supplies and Dressing (other  
   than items of personal comfort or  
   cosmetic)

Overhead Trapeze Equipment  
 Oxygen Equipment (such as IPPB  
   machines and oxygen tents)  
 Oxygen Mask  
 Pads  
 Peroxide  
 Pitcher  
 Plastic Bib  
 Pump (aspiration and suction)  
 Restraints  
 Room and Board (semiprivate or  
   private if necessitated by a medical or  
   social condition)  
 Sand Bags  
 Scalpel  
 Sheepskin  
 Special Diets  
 Specimen Cups  
 Sponges  
 Steam Vaporizer  
 Sterile Pads  
 Stomach Tubes  
 Stool Softeners, Nonlegend  
 Suction Catheter  
 Suction Machines  
 Suction Tube  
 Surgical Dressings (including sterile  
   sponges)  
 Surgical Pads  
 Surgical Tape  
 Suture Removal Kit  
 Suture Trays  
 Syringes (all sizes)  
 Syringes, Disposable  
 Tape (for laboratory test)  
 Tape (nonallergic or butterfly)  
 Testing Sets and Refills (S & A)  
 Tongue Depressors  
 Tracheostomy Sponges  
 Tray Service  
 Tubing I.V. Trays, Blood Infusion  
   Set, I.V. Tubing  
 Underpads  
 Urinary Drainage Tube  
 Urinary Tube and Bottle  
 Urological Solutions  
 Vitamins, Nonlegend  
 Walkers  
 Water Pitchers  
 Wheelchairs

*AUTHORITY: sections 208.153, 208.159, and 208.201, RSMo 2016. \* This rule was previously filed as 13 CSR 40-81.083. Original rule filed Aug. 13, 1982, effective Nov. 11, 1982. Rescinded: Filed July 12, 1984, effective Oct. 11, 1984. Readopted: Filed July 3, 1986, effective Nov. 1, 1986. Amended: Filed Dec. 16, 1986, effective April 26, 1987. Emergency amendment filed June 19, 1987, effective July 1, 1987, expired Oct. 29, 1987. Amended: Filed Aug. 18, 1987, effective Oct. 25, 1987. Emergency amendment filed Feb. 5, 1988, effective Feb. 15, 1988, expired June 13, 1988. Amended: Filed Feb. 5, 1988, effective June 11, 1988. Emergency amend-*

*ment filed Dec. 16, 1988, effective Jan. 1, 1989, expired May 1, 1989. Amended: Filed Dec. 5, 1988, effective Feb. 24, 1989. Amended: Filed Dec. 16, 1988, effective March 11, 1989. Amended: Filed Aug. 16, 1989, effective Nov. 11, 1989. Amended: Filed Dec. 1, 1989, effective Feb. 25, 1990. Rescinded and readopted: Filed March 5, 1990, effective June 11, 1990. Amended: Filed May 30, 1990, effective Sept. 28, 1990. Emergency amendment filed Nov. 15, 1991, effective Dec. 3, 1991, expired April 1, 1992. Emergency amendment filed March 13, 1992, effective April 2, 1992, expired July 30, 1992. Amended: Filed Nov. 15, 1991, effective April 9, 1992. Emergency amendment filed July 17, 1992, effective Sept. 1, 1992, expired Dec. 29, 1992. Emergency amendment filed Dec. 8, 1992, effective Dec. 31, 1992, expired April 28, 1993. Amended: Filed July 17, 1992, effective April 8, 1993. Amended: Filed Dec. 14, 1992, effective June 7, 1993. Amended: Filed Nov. 21, 1994, effective June 30, 1995. Emergency amendment filed Dec. 15, 1995, effective Jan. 1, 1996, expired June 28, 1996. Amended: Filed Oct. 10, 1995, effective May 30, 1996. Amended: Filed Oct. 16, 1995, effective May 30, 1996. Emergency amendment filed Feb. 23, 1999, effective March 5, 1999, expired Aug. 31, 1999. Amended: Filed May 27, 1999, effective Nov. 30, 1999. Emergency amendment filed Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Amended: Filed Feb. 14, 2001, effective Aug. 30, 2001. Emergency amendment filed Jan. 24, 2007, effective Feb. 3, 2007, expired Aug. 1, 2007. Amended: Filed Jan. 16, 2007, effective July 30, 2007. Emergency amendment filed June 20, 2007, effective July 1, 2007, expired Dec. 27, 2007. Amended: Filed June 20, 2007, effective Jan. 30, 2008. Emergency amendment filed June 18, 2008, effective July 1, 2008, expired Dec. 28, 2008. Amended: Filed July 1, 2008, effective Jan. 30, 2009. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 29, 2012. Amended: Filed Sept. 20, 2011, effective March 30, 2012. Amended: Filed Dec. 13, 2013, effective June 30, 2014. Emergency amendment filed Aug. 15, 2016, effective Sept. 1, 2016, expired Feb. 27, 2017. Amended: Filed Aug. 15, 2016, effective March 30, 2017. Emergency amendment filed Aug. 22, 2017, effective Sept. 1, 2017, expired Feb. 27, 2018. Amended: Filed Aug. 22, 2017, effective Feb. 28, 2018.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.*

**13 CSR 70-10.040 Medicaid Eligibility and Preadmission Screening for Mentally Ill and Mentally Retarded Individuals**

*PURPOSE:* This rule outlines the preadmission screening requirements related to eligibility for Title XIX.

*PUBLISHER'S NOTE:* The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.

(1) An individual who is admitted to a Medicaid certified bed on or after January 1, 1989, and has not been screened for mental illness and mental retardation prior to admission to a Medicaid-certified nursing facility (NF) bed or who does not have a valid special admission exemption will not be eligible for Title XIX payments to be made on his/her behalf for NF services.

(A) This rule incorporates by reference 42 Code of Federal Regulations (CFR) 483.20(m)(1) and (2).

(B) For purposes of this rule an individual is considered to have mental illness if the individual has a serious mental illness as defined in 42 CFR 483.102(b)(1) which is hereby incorporated by reference.

(C) For purposes of this rule an individual is considered to be mentally retarded if the individual is mentally retarded as defined in 42 CFR 483.102(b)(3), which is hereby incorporated by reference, or is a person with a related condition as described in 42 CFR 435.1009, which is hereby incorporated by reference.

(2) The requirement for preadmission screening applies whether the individual is a Medicare beneficiary, Medicaid recipient or private pay.

(3) Preadmission screening and resident reviews (PASARR) will include an assessment of the individual's:

(A) Physical condition;

(B) Mental condition; and

(C) Need for specialized services for mental illness or mental retardation.

(4) For purposes of this rule, the term "specialized services" is defined for individuals with—

(A) Mental illness as the implementation of an individualized plan of care developed under and supervised by a physician, provided by a physician and other qualified mental health professionals, that prescribes specific thera-

pies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness which necessitates supervision by trained mental health personnel; and

(B) Mental retardation or other related condition(s) as a continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and services that are directed towards the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal function status. Specialized services do not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous treatment program.

(5) Medical information needed to do the assessments will be furnished by the attending physician. Other information needed to make the assessments, such as social history and behavior, may be furnished by the individual, guardian, family members, social workers or other persons.

(6) The preadmission screening and resident review process will be divided into two (2) parts: Level I and Level II.

(A) The purpose of a Level I screening is to identify a nursing facility applicant or resident who is known or suspected to be mentally ill, mentally retarded or developmentally disabled.

(B) The purpose of a Level II screening is to confirm that the individual is mentally impaired and to determine whether the individual needs specialized services and determine if a nursing facility is an appropriate setting. If a determination is made that placement in an NF is inappropriate, no Title XIX vendor payments will be made or continue to be made in the case of a resident already in the NF.

(7) Any individual identified to be or suspected to be mentally ill, mentally retarded or developmentally disabled by the Level I screening may require a Level II screening. A Level II screening must be performed prior to admittance into a certified bed located in an NF, unless a valid special admission category applies.

(A) The Level II screening shall be performed by the Department of Mental Health or its designee. If a review indicates that specialized services are required at a level of care that can only be furnished in an intermediate care facility for the mentally retarded (ICF/MR), within the Home and Community-Based Waiver for the Developmentally Disabled or an acute care mental hospital, that individual is inappropriate for admission or

continued stay in an NF. This will be true even if the individual meets the eighteen (18)-point count under 13 CSR 15-9.030 needed for authorization of Medicaid nursing facility payments.

1. If an individual described in subsection (7)(A) has medical needs which can only be met in an NF, as confirmed by and recommended by a Level II screening and communicated to the nursing facility by the Division of Aging, that individual may be admitted or continue to remain in an NF. If the medical condition improves and nursing needs could be met in other settings, the individual shall be discharged.

2. Notice of a decision resulting from a Level II screening shall be sent by the Division of Aging to the referring entity who submitted the Level I screening forms and the proposed placement facility, if different.

(B) Any individual suspected of being mentally ill, mentally retarded or developmentally disabled by the Level II process and who has been admitted to an NF shall be subject to a Level II preadmission screening/resident review. Any individual determined through the Level II process to be mentally ill, mentally retarded or developmentally disabled and to require specialized services shall be discharged if a Level II screening determines nursing care needs can be met in other settings regardless of the point count under 13 CSR 15-9.030.

(C) Special admission categories are as follows:

1. A person who qualifies for a special admission category shall have mental health screen performed as detailed per the following:

A. Terminal illness. The person is certified by a physician to be terminally ill. As defined by the Social Security Act an individual is considered to be terminally ill if there is a medical prognosis that the individual's life expectancy is six (6) months or less; and

B. Severely ill. The person is comatose, ventilator dependent, functions at brain stem level or has a diagnosis of chronic obstructive pulmonary disease, severe Parkinson's disease, Huntington's disease, Amyotrophic Lateral Sclerosis or congestive heart failure which results in a level of physical impairment so severe the individual could not be expected to benefit from specialized services; and

2. The following special admission categories may require a mental health evaluation following admission:

A. Direct transfer from a hospital—If a physician attests that the individual is likely to need thirty (30) days or less of nursing facility care for the condition for which the individual was hospitalized, no Level II screening is necessary and the individual is exempt from the PASARR process. Nursing





facility payment will be made for no more than thirty (30) days. If it becomes apparent that the individual will need longer than thirty (30) days, the facility must immediately notify the Division of Aging. If a continued stay is approved, a Level II screening may be performed;

B. Emergency provisional admission—This category is for a situation in which an individual needs placement to protect the individual from serious physical harm to self or others. The nursing facility must contact the Division of Aging Elderly Abuse/Neglect hotline to make a formal request. This special admission category requires prior authorization by the Division of Aging as an emergency. No more than seven (7) days will be allowed for an emergency admission. The Division of Family Services will manage those dates based on information from the Division of Aging. If the resident needs to stay in the facility longer than seven (7) days, the facility must immediately notify the Division of Aging to determine continued stay. A Level II screening may be performed after the initial seven (7)-day period; and

C. Respite care—An individual may be admitted and remain in a facility for thirty (30) consecutive days or less with a forty-two (42)-day maximum in twelve (12) months in order to provide respite for the individual's caregiver. A Level II screening is not required. The Division of Family Services will control the nursing facility authorized payment dates by means of a form they send to the state office. No payment will be made to the nursing facility beyond the thirty (30) days. If a situation arises in which the stay is longer than thirty (30) days, the nursing facility must contact the Division of Aging. If a continued stay is authorized, a Level II screening may be performed.

(8) The Department of Social Services and the Department of Mental Health will have joint responsibility for the preadmission screening process.

*AUTHORITY:* sections 208.153, and 208.201, RSMo 1994.\* *Emergency rule filed Dec. 30, 1988, effective Jan. 10, 1989, expired April 29, 1989. Original rule filed Feb. 15, 1989, effective April 27, 1989. Amended: Filed June 6, 1989, effective Aug. 24, 1989. Amended: Filed July 23, 1991, effective Dec. 9, 1991. Amended: Filed May 27, 1999, effective Jan. 30, 2000.*

\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991 and 208.201, RSMo 1987.

### 13 CSR 70-10.050 Pediatric Nursing Care Plan

*PURPOSE:* This rule establishes a methodol-

*ogy for determination of per diem rates for pediatric long-term care facilities.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material. The forms mentioned in this rule follow 13 CSR 70-10.010.*

(1) Authority. This rule is established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services to promulgate rules.

(2) Purpose. This rule establishes a methodology for determination of per diem rates for pediatric nursing care facilities.

(3) General Principles.

(A) Provisions of this reimbursement plan shall apply only to pediatric nursing facilities (NFs) certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The per diem rates determined by this regulation shall apply only to services provided on or after July 1, 1989.

(C) The effective date of this plan shall be July 1, 1989.

(D) The Missouri Medical Assistance (Medicaid) Program shall provide reimbursement for pediatric nursing care services based solely on the individual Medicaid-eligible recipient's covered days of care (within benefit limitations) multiplied by the facility's Medicaid per diem rate. No payments may be collected or retained in addition to the Medicaid per diem rate for covered services. Where third-party payment is involved, Medicaid will be the payer of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services. A provider participating under this rule shall not be eligible for participation under any other Missouri Medicaid plan for the provision of nursing care services.

(E) The Medicaid per diem rate shall be the lesser of—

1. The average private pay rate;
2. The Medicare (Title XVIII) per diem rate, if applicable;
3. The per diem rate as determined in accordance with section (11); or
4. The level-of-care ceiling. Effective

July 1, 1999, the level-of-care ceiling shall be the weighted average Medicaid allowable cost for all participating pediatric nursing facilities as determined from their 1992 cost reports adjusted by the same percentages stated in 13 CSR 70-10.015 for 1992 cost reports and any negotiated trend factors effective through July 1, 1999. The weighted average rate is three hundred twenty-one dollars and forty-five cents (\$321.45) as of July 1, 1999. Effective January 1, 2002, the level-of-care ceiling will be split for that portion related to the patient care and general and administrative per diems and for that portion related to the capital per diem. The level-of-care ceiling for patient care and general and administrative per diems effective January 1, 2002, is three hundred eighteen dollars and sixty-three cents (\$318.63) and the capital per diem level-of-care ceiling is seven dollars and forty-four cents (\$7.44). For any facility which the capital per diem rate is calculated based on subparagraph (11)(A)3.B., the fair rental value system, the capital per diem level-of-care ceiling will not be applied. The level-of-care ceiling shall be adjusted by the negotiated trend factor given in subsection (13)(A) or any global adjustment in section (13) of 13 CSR 70-10.015.

(F) For a change in ownership, management, control, operation or leasehold interest by any form for any facility certified for participation in the Medicaid program at any time, increased capital costs for the successor owners, management or leaseholder shall not be recognized for purposes of reimbursements.

(G) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A per-diem reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid program shall be assigned a provider number by the Division of Medical Services. Facilities previously certified shall retain the same provider number regardless of any change in ownership, management, control, operation or leasehold interest in any form.

(I) Regardless of changes of ownership, management, control, operation or leasehold interests by whatever form for any facility certified for participation in the Medicaid Program, the division will issue allowable reimbursements to the facility identified in the current Medicaid participation agreement, and recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid Program.

(J) A facility's allowable costs shall be apportioned between Medicaid recipients and





other patients so that the share borne by the Medicaid Program is based upon services actually provided to Medicaid recipients. A facility's allowable costs allocated to the Medicaid Program in no case may include costs incurred in providing services for persons who are not Medicaid eligible.

(K) A facility that also is certified for participation in the Title XVIII (Medicare) Program shall meet the requirements of Title XVIII of the Social Security Act. Any facility which is terminated from participation in the Medicare Program also shall be terminated from participation in the state's Medicaid Program.

(L) No restrictions or limitations shall be placed on a recipient's right to select providers of his/her own choice.

#### (4) Definitions.

(A) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this rule. The allowability of costs not addressed specifically in this rule shall be determined by the Division of Medical Services. This determination may be based upon criteria such as the *Medicare Provider Reimbursement Manual* (HIM-15) and section (7) of this rule.

(B) Asset value. The asset value is the per bed cost of construction used in calculating a facility's capital per diem utilizing the fair rental value system as set forth in subparagraph (11)(A)3.B. The cost of construction is based on the RS Means Building Construction Cost Data to determine specific cost information for current, historical and projected costs. The initial asset value was based on 1994 costs utilizing the median total cost per bed of the national average cost of construction for nursing home beds from the Square Foot Table, adjusting it for the Missouri cities indexes from the City Cost Indexes Table, and adding the per bed land cost determined by the division. This initial asset value will be adjusted annually using the estimated Historical Cost Indexes from the RS Means publication for each subsequent year. The resulting asset values are included in Appendix C.

(C) Average private pay rate. The usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into revenue collected from the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with state or federal agencies, such as the Veterans Administration and the Missouri Department of Mental Health.

(D) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in subsection (10)(A) of this rule and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering

both covered and noncovered services for the fiscal reporting period in accordance with the procedures prescribed by the division.

(E) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(F) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(G) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(H) The Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure of LTC facilities.

(I) The Division of Medical Services. Unless otherwise designated, division as used in this regulation refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(J) Entity. Any natural person, corporation, not-for-profit corporation, professional corporation, business, partnership or something that exists as a particular and distinct unit.

(K) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(L) Generally accepted accounting principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing these principles.

(M) Long-term care (LTC) facility. A licensed skilled nursing facility (SNF), intermediate care facility (ICF), ICF/mentally retarded (MR), SNF/ICF, residential care facility I (RCF I), residential care facility II (RCF II) or other provider of LTC services.

(N) New facility. A newly built facility, for which an approved CON or applicable waiver was obtained and which was newly completed and operational on or after July 1, 1989, and which was originally certified for participation as an SNF.

(O) Occupancy. A facility's total actual patient days divided by the total licensed bed days for the same period.

(P) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. Patient day includes the twelve (12) temporary leave of absence days per any period of six (6) consecutive months for which the Medicaid Program will reimburse the provider. The day of discharge is not a patient day for reimbursement purposes unless it is also the day of admission.

(Q) Pediatric nursing care (facility). Either a new facility with all of the following attributes, or an LTC facility with a valid Medicaid participation agreement in effect on June 30, 1989, with all of the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198, RSMo and must have any other licenses, permits, or both, which may be required by applicable state and local laws;

2. The facility must have one hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as an SNF;

3. The facility cannot be either attached to or a distinct part of any other LTC facility or hospital. Distinct part means any portion of any LTC facility or hospital, less than the total beds of the LTC facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(R) Provider. Either a new facility with all of the following attributes, or an LTC facility with a valid Medicaid participation agreement in effect on June 30, 1989, with all of the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198, RSMo and must have any other licenses, permits, or both, which may be required by applicable state and local laws;

2. The facility must have one hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as an SNF;

3. The facility cannot be either attached to or a distinct part of any other LTC facility or hospital. Distinct part means any portion of any LTC facility or hospital, less than the total beds of the LTC facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(S) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in those dealings;

2. An entity has an ownership or controlling interest in another entity and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the



other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility; or

3. As used in this section, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest is when an entity—

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust note or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

D. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(T) Replacement beds/facility. A newly constructed pediatric nursing care facility, or any part thereof, built to replace beds that were located in a pediatric nursing care facility that are no longer used to provide pediatric nursing care facility services.

(U) Restricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(V) Second prior year cost report. The cost report for the facility fiscal year which ends in the second calendar year prior to the calendar year in which the state's fiscal year

ends. For example, for state Fiscal Year 1990, the second prior year cost report would be the cost report for a facility fiscal year which ends any time in calendar year 1988.

(W) Skilled nursing facility (SNF). An LTC facility licensed and certified by the Division of Aging as meeting the conditions for participation in the Medicaid Program as an SNF.

(X) Unrestricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident as necessary, and the facility may not charge the resident, any entity or any other payer any additional amounts for these items, except that supplies and services which would otherwise be covered in a per-diem rate but which are also billable to the Title XVIII Medicare Program must be billed to that program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and supplies which must be provided by SNFs as set forth in Title 42 *Code of Federal Regulations*;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech and the like;

(D) Temporary leave of absence days, not to exceed twelve (12) days per any period of six (6) consecutive months;

(E) Provision of nursing services;

(F) Provision of personal hygiene and routine care services;

(G) All laundry service, including personal laundry;

(H) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(I) All consultative services required by federal or state law or rule;

(J) All therapy services required by federal or state law or rule;

(K) All routine care items, including disposables and including, but not limited to, those items specified in Appendix A to this rule;

(L) All nursing care services and supplies, including disposables, and including, but not limited to, those items specified in Appendix A to this rule; and

(M) Any and all nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and

are included in a facility's per-diem rate.

(6) Noncovered Supplies, Items and Services. All supplies, items and services which are not either covered in a facility's per-diem rate, billable to another program in the Missouri Medical Assistance (Medicaid) Program, or billable to Medicare or other third-party payors. Noncovered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc.;

(B) Bed reservations for recipients who are away from the facility for any reason other than a temporary leave of absence day. Temporary leave of absence days in excess of twelve (12) per any period of six (6) consecutive months are noncovered;

(C) Supplies, items and services for which payment is made under Missouri Medical Assistance (Medicaid) Program directly to a provider or providers other than providers of the pediatric nursing care services, including, but not limited to, those set forth in Appendix B to this rule; and

(D) Supplies, items and services provided nonroutinely to residents for personal comfort or convenience, including, but not limited to, those set forth in Appendix B to this rule.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area, provided the services are actually performed, are necessary and are reasonable.

2. Compensation shall mean the total benefit, within the limitations set forth in this rule, received by the owner for the services s/he renders to the facility, including direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this rule. Compensation must be paid (whether in cash, negotiable instrument or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual (PRM)*, Part 1, Section 906.4.

3. Reasonableness of compensation shall be limited as prescribed in subsection (8)(T).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the owner not rendered these services, then employment of another entity to perform the



service would be necessary.

(B) Covered services and supplies as defined in section (5) of this rule.

(C) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility.

(D) Value of Services of Employees. Except as provided for in this rule, the value of services performed by employees or contractors in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the contractor.

(E) Fringe Benefits.

1. Retirement plans.

A. Contributions to retirement plans for the benefit of employees excluding stockholders, partners and proprietors of the provider shall be allowable cost areas provided these plans meet the qualifications established in the *Internal Revenue Code* of 1985, as amended in the requirements for Title XVIII. Interest income from funded pension or retirement plans shall be excluded from consideration in determining the allowable costs area.

B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report form.

2. Deferred compensation plans.

A. Contributions for the benefit of employees, excluding stockholders, partners and proprietors under deferred compensation plans shall be all allowable cost areas when, and to the extent that, these costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report form.

(F) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance in writing by the division.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

(G) Advertising Costs. Advertising costs which are reasonable and appropriate.

(H) Cost of Supplies Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the uniform cost report, a provider shall identify related-party suppliers and the type, quantity and costs of goods and services obtained from each supplier.

(I) Interest and Borrowing Costs on Capital Asset Debt.

1. Interest and borrowing costs related to necessary loans associated with capital asset debt are accounted for in the capital cost component and are subject to debt and interest rate restrictions. Determination of allowable interest and borrowing costs is detailed in parts (11)(A)3.B.(III) and (11)(A)3.B.(IV).

2. Loans must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required, identifiable in the provider's accounting records, related to the reporting period in which the costs are claimed, and necessary for the operation, maintenance or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight line basis. Borrowing costs include loan costs (i.e. lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), prepaid interest and discounts. Finder's fees are not allowed.

(J) Utilization Review. Costs incurred for the performance of required utilization review.

(8) Nonallowable Costs. Cost not reasonably related to pediatric nursing care facility services shall not be included in a provider's costs. In accordance with this section, contractual allowances, courtesy discounts, charity allowances and similar adjustments or allowances are offsets to revenue and are not included in allowable costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Amortization on intangible assets;

(B) Attorney fees related to litigation;

(C) Bad debts;

(D) Capital cost increases due solely to changes in ownership, management, control, operation or leasehold interest;

(E) Central office or pooled costs not reasonably attributed to the efficient and economical operation of the facility;

(F) Charitable contributions;

(G) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under sub-

section (7)(A) of this rule;

(H) Cost arising from joint use of resources (including central office and pooled cost) not directly related to patient care;

(I) Cost not directly related to the provision of patient care;

(J) Cost of ancillary services covered by Medicare Part B;

(K) Cost (for example, legal fees, accounting and administration costs, travel costs and the costs of feasibility studies) which is attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(L) Directors' fees from any source;

(M) Federal, state or local income and excess profit taxes, including any interest and penalties paid on them;

(N) Finders' fees;

(O) Franchise taxes;

(P) Fund-raising expenses;

(Q) Interest expense on intangible assets;

(R) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(S) Noncovered supplies, services and items as defined in section (6);

(T) Owners' compensation in excess of the high range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare Provider Reimbursement Manual (PRM) Part 1, Section 905.2.*;

(U) Prescription drugs;

(V) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Cost associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(W) Research costs;

(X) Resident personal purchases;

(Y) Return on equity;

(Z) Salaries, wages or fees paid to non-working officers, employees or consultants;

(AA) Self-employment taxes;

(BB) Stockholder relations or stock proxy expenses;

(CC) Taxes or assessments for which exemptions are available;

(DD) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(EE) Vending machines and related supplies.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report if included in gross revenues. These revenues include, but are not limited to, the following:

1. Income from telephone services;

2. Sale of employee and guest meals;



3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;
5. Rental income;
6. Cash, trade, quantity, time and other discounts;
7. Purchase rebates and refunds;
8. Recovery on insured loss;
9. Parking lot revenues;
10. Vending machine commissions or profits;
11. Sales from drugs to individuals other than Medicaid recipients;
12. Interest income to the extent of interest expense;
13. Any income from investments;
14. Room reservation charges in excess of covered therapeutic home leave days;
15. Private room differential; and
16. Reimbursement for nurse-aid training which is not provided as part of the per-diem rate.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs if the interest is applied to the asset being depreciated.

(C) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(D) Restricted funds designated by the donor for future capital expenditures will not be offset from allowable expenses at any time.

(E) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(F) Unrestricted funds received from endowments will not be offset from allowable cost.

(G) As applicable, restricted and unrestricted funds will be offset in each cost category, except capital, in an amount equal to each category's proportionate share of allowable expense. The applicable categories are patient care costs and general and administrative costs as defined in section (11).

(H) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

#### (10) Provider Reporting and Record Keeping Requirements.

##### (A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division of Medical Services an annual cost report, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted

on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this rule.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified-cash basis of accounting may continue to report on that basis, provided appropriate treatment under GAAP of capital expenditures is made.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation and retain all payments which have been withheld pursuant to this provision.

7. Authenticated copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, within ten (10) days of filing the returns;

G. Leases, rental agreements, or both, related to the activities of the provider;

H. Management contracts;

I. Medicare cost report;

J. Statement verifying the restriction as specified by the donor, prior to donation, for all restricted grants; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Cost reports must be fully, clearly and accurately completed, all required attach-

ments must be submitted and any requests for additional information or clarification must be provided before a cost report is considered complete. If any additional information, documentation or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the request, payments will be withheld from the facility until the information is submitted. If information requested is not received by June 1 prior to the rate determination date, rate increases based upon the cost report will not be effective until sixty (60) days after receipt of requested information, and rate decreases based upon the cost report will be retroactive to the July 1 rate determination date.

9. The division will not accept amended cost reports for rate determination unless they are received by March 31 prior to the rate determination date. Under no circumstances will the division accept amended cost reports for rate redetermination after the rate has been established.

##### (B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by one (1) of the following persons authorized by the governing body of the provider to make the certification: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of the authorization shall be furnished upon request.

2. Cost reports must be notarized by a licensed notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by \_\_\_\_\_

(Provider name(s) and number(s))  
for the cost report period beginning \_\_\_\_\_, 19\_\_\_\_ and ending \_\_\_\_\_, 19\_\_\_\_, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)  
(C) Adequate Records and Documentation.



1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be maintained separately with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. A provider must retain all records and documentation for seven (7) years from the cost report filing date. All current providers, regardless of length of participation in the Medicaid Program, are responsible for providing access to the facility's records and documentation for seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, the provider shall transfer the records to the same facility at which the Medicaid services were provided or to another in-state location that is acceptable to the division or its authorized agent. The provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform the field audit in any out-of-state location, if the location is acceptable to the division.

(E) Change in Provider Status.

1. Upon termination of participation in the Medicaid Program or change of ownership, the provider is required to submit a cost report for the period ending with the date of termination or change, regardless of its tax period. The fully completed cost report with all required attachments and documentation is due within forty-five (45) days after the date of termination or change.

2. If a cost report is more than ten (10) days past due, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the pediatric nursing care facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled or managed by an entity(ies) that owns, controls or manages one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Allocation of central office or pooled costs to individual facilities shall be consistent from year-to-year. If a desk review or field audit establishes that records are not maintained so as to clearly identify information required by this rule, none of the commingled cost shall be recognized as allowable cost in determining the facility's Medicaid per-diem rate. Allowability of these costs shall be determined in accordance with the provisions of this rule.

3. Certain home office or related management company costs that would otherwise be reported in the patient care component of the cost report if the facility performed the services or purchased the services independently, may be reported in the patient care cost category, if services were actually rendered at the individual facility. Allocation of these costs must be based on the hours worked on-site in an individual facility. Direct patient service cost not meeting these requirements shall be reported in the general and administrative cost category.

(11) Rate Determination.

(A) Except as provided in subsection (11)(B), and subject to the timely filing provisions of section (10), a facility's per-diem rate shall be determined on July 1 of each state fiscal year, beginning July 1, 1989, or the qualification date, whichever is later, based upon the data contained in the desk-reviewed or field-audited second prior year cost report, or both; provided, the reported costs are allowable, covered, properly apportioned, properly allocated and properly classified as prescribed elsewhere in this rule. A facility's per-diem rate shall be the sum of the patient care per-diem rate, the general and administrative per-diem rate and the capital per-diem rate. Applicable trend factors shall be applied only to the patient care component of the per-diem rate. Applicable trend factors as used in this section are the trend factors that were authorized subsequent to the last day of the facility fiscal year covered by the second prior year cost report, up to and including the trend factor adjustment which may be authorized on July 1 when the annual rate is determined. Procedures for determination of the per-diem rates in each cost category are as follows:

1. Patient care. From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate patient care costs from lines forty-five through sixty (45-60), and sixty-two through seventy-five (62-75), seventy-seven through eighty-five (77-85), eighty-seven through ninety-five (87-95), ninety-seven through one hundred three (97-103), line one hundred five (105) and lines one hundred thirteen through one hundred twenty (113-120). The accumulated patient care costs will be divided by the patient days for the reporting period identified from line eight (8), item six (6), column eight (8). The result of this procedure will be the Patient Care Per-Diem Rate;

2. General and administrative. From the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, accumulate general and administrative costs from line one hundred nine (109), line one hundred eleven (111), line one hundred twelve (112) and lines one hundred twenty-two through one hundred fifty (122-150). The accumulated general and administrative costs will be divided by the greater of patient days for the reporting period from line eight (8), item six (6), column eight (8) or ninety percent (90%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The General and Administrative Per-Diem Rate shall be the lesser of—

A. The results of the procedure described in paragraph (11)(A)2.; or

B. Fifteen percent (15%) times the results of the procedure described in paragraph (11)(A)1.; and

3. Capital.

A. For LTC facilities which were certified for participation in the Medicaid Program at any time prior to June 30, 1989, and with valid participation agreements in effect on June 30, 1989, and which satisfy all the qualifications necessary for participation in the pediatric nursing care program described in this rule, the per-diem rate for capital under this rule shall be the sum of lines one hundred and six (106), one hundred seven (107), one hundred eight (108) and one hundred ten (110) from the Financial and Statistical Report for Nursing Facilities portion of the applicable cost report, divided by the greater of patient days for the reporting period from line eight (8), item six (6), column eight (8) or ninety-three percent (93%) of the total bed days for the reporting period from line eight (8), item five (5), column eight (8). The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13). If a facility replaces all beds with a new facility, the capital per-diem rate will be determined by subparagraph (11)(A)3.B.

B. For new facilities, replacement beds/facility and additional beds, the per-diem



rate for capital shall be determined using the fair rental value system (FRV), which consists of four (4) elements: rental value, return, computed interest, and borrowing costs. The determination of the per diem for each element is as follows:

(I) Rental value. The rental value is a computed figure determined as follows:

(a) Determine the total asset value.

I. Determine facility size from the rate setting cost report;

II. Determine the number of increased licensed beds through the end of the rate setting period;

III. Determine the bed equivalency for renovations/major improvements by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. For a rate setting cost report, the renovation/major improvement must be completed by the end of the rate setting period. The cost must be at least the asset value per bed for the year of the renovation/major improvement.

IV. Determine the number of decreased licensed beds through the end of the rate setting period;

V. Determine the total facility size which is the sum of items I., II., III. less IV; and

VI. Determine the total asset value which is the total facility size multiplied by the asset value relating to the rate setting cost report as set forth in subsection (4)(B).

(b) Determine the reduction for age by multiplying the age of the beds by one percent (1%). The result of the reduction for age by multiplying the age of the beds by one percent (1%).

I. The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1979 of sixty (60) beds, an additional licensure of sixty (60) beds in 1984, and an additional licensure of ten (10) beds in 1998, with a rate setting cost report ending in 2000, the reduction is calculated as follows:

Licensure Year	Age	Age times	
		Beds	Beds
1979	21	60	1,260
1984	16	60	960
1998	2	10	20
Total		130	2,240

Weighted Average Age—2,110/130 beds = 17.23 years rounded to 17 years.

This results in a reduction for age of the beds at 17%.

II. The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole

year as set forth in the Certificate of Need (CON). For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1998, the reduction is calculated as follows:

Licensure Year	Age	Age times	
		Beds	Beds
1978	22	60	1,320
1998	2	60	120
Total		120	1,440

Weighted Average Age—1440/120 beds = 12.00 years.

This results in a reduction for age of the beds at 12%.

III. The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year as set forth in the CON. For example, a facility with original licensure in 1979 of sixty (60) beds, an additional licensure of sixty (60) beds in 1984, an additional licensure of ten (10) beds in 1998 and a reduction of ten (10) beds in 1989, the reduction percentage is calculated as follows:

Licensure Year	Age	Age times	
		Beds	Beds
1979	21	60	1,260
1984	16	60	960
1998	2	10	20
1989*	21	(10)	(210)
Total		120	2,030

\*reduction of 1979 beds

Weighted Average Age—2,030/120 = 16.92 years rounded to seventeen (17) years.

This results in a reduction for age of the beds at 17%.

IV. The age of the bed equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120) bed facility licensed in 1979 undertakes two (2) renovations: \$200,000 in 1983 and \$100,000 in 1993. The asset value per bed is \$25,250 for 1983 and \$32,039 for 1993. The bed equivalency is eight (8) beds for 1983 and three (3) beds for 1993; the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Age times	
		Beds	Beds
1979	21	120	2,520
1983	17	8	136
1993	7	3	21
Total		131	2,677

Weighted Average Age—2,677/131 = 20.44 year rounded to twenty (20) years.

This results in a reduction for age of the beds at 20%.

(c) Determine the facility asset

value. The facility asset value is the total asset value per part (11)(A)3.B.(I) less the reduction for age per part (11)(A)3.B.(II).

(d) Determine the rental value. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty (40)-year life.

(e) The following is an illustration of how parts (11)(A)3.B.(I), (II), (III) and (IV) determine the rental value.

I. Assumptions:

2000 Rate Setting Cost Report	
Licensed beds	120
Bed Equivalents	4
Weighted average age of the beds	23 years
Asset value—2000	\$ 34,797

II. The total asset value is the product of the total facility size times the asset value:

Total facility size	124
Asset value	× \$ 34,797
Total asset value	\$4,314,828

III. The facility asset value is the total asset value less the reduction for age of the beds:

Total asset value	\$4,314,828
Reduction for age (23%)	\$ 992,410
Facility asset value	\$3,322,418

IV. The rental value is the facility asset value multiplied by 2.5%.

Facility asset value	\$3,322,418
	× 2.5%
Rental value	\$ 83,060

(II) Return. The return is a computed figure, subject to rate limitations, as set forth below:

(a) Reduce the facility asset value by the capital asset debt, but not less than zero (0), times the rate of return. The rate of return is the yield for the thirty (30)-year Treasury Bond as reported by the Federal Reserve Board and published in the *Wall Street Journal* at the end of the first week in September, plus two (2) percentage points.

(b) The debt associated with increases in licensed beds or renovations/major improvements for rate setting cost reports as set forth in items (11)(A)3.A.(I)(a)II. and III., will be added to the capital asset debt from the rate setting cost report. The facility shall provide adequate documentation to support the additional debt as required in subsection (7)(I). If adequate documentation is not provided to support the additional capital asset debt, it will be assumed to equal zero (0).

(c) The following is an illustration of how subpart (11)(A)3.A.(II)(a) is calculated continuing the example from above in (11)(A)3.A.(I) and assuming capital asset debt of \$1,371,094:



Facility asset value	\$3,322,418
Capital asset debt	<u>(\$1,371,094)</u>
	<u>\$1,951,324</u>
Rate of Return	<u>× 9.18%</u>
Return	<u>\$ 184,986</u>

(III) Computed interest. The interest is a computed figure, subject to capital debt and interest rate limitations, as set forth below:

(a) Interest will be calculated by multiplying the lesser of the necessary outstanding capital asset debt or the facility asset value as determined in subpart (11)(A)3.B.(I)(c) by the Chase Manhattan prime rate in effect on the first business day in September, as published in the *Wall Street Journal*, plus two (2) percentage points. The interest rate in effect at the end of the rate setting period shall be used.

(b) The following is an illustration of how interest is calculated:

Assumptions:

	Example A: Facility Asset Value < Debt	Example B: Facility Asset Value > Debt
Facility asset value	\$3,322,418	\$3,322,418
Outstanding capital asset debt	\$3,500,000	\$1,951,324
Term of debt	25 years	25 years
Prime rate—September 1, 1999	8.25%	8.25%
Interest calculation:		
The lesser of the facility asset value or the outstanding capital asset debt multiplied by the allowable interest rate (prime rate + 2%)		
	Example A	Example B
Facility asset value	\$3,322,418	
Outstanding capital debt		\$1,951,324
Interest rate	<u>× 10.25%</u>	<u>× 10.25%</u>
Computed interest	<u>\$ 340,548</u>	<u>\$ 200,011</u>

(IV) Borrowing costs.

(a) A provider shall capitalize borrowing costs and amortize them over the life of the loan on a straight line basis.

(b) If loans for capital asset debt exceed the facility asset value, the borrowing costs associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

(c) The following is an illustration of how allowable borrowing costs are calculated:

Assumptions:	
Loan costs	\$120,000
Discount costs	<u>\$125,000</u>
Borrowing costs	<u>\$245,000</u>

	Example A	Example B
Facility asset value	\$3,322,418	\$3,322,418
Outstanding capital asset debt	<u>/\$3,500,000</u>	<u>/\$1,951,324</u>
Percent of borrowing costs allowed	95%	100%
Borrowing costs	<u>× \$ 245,000</u>	<u>× \$ 245,000</u>
Allowable portion to be amortized	\$ 232,750	\$ 245,000
Term of debt	<u>/ 25 yrs</u>	<u>/ 25 yrs</u>
Allowable borrowing costs	<u>\$ 9,310</u>	<u>\$ 9,800</u>

(V) Capital per-diem calculation.

Two (2) per diems are calculated using the above computed figures and summed to determine the total capital per-diem rate, as set forth below.

(a) FRV per diem. A per diem is calculated by dividing the sum of the rental value, the return and the computed interest by the annualized patient days. Annualized patient days equals the total facility size determined in item (11)(A)3.B.(I)(a)V. times three hundred sixty-five (365) adjusted by the greater of ninety percent (90%) or the facility's occupancy from the rate setting cost report. The following is an illustration of how this is calculated:

Rental Value	\$ 83,060
Return	\$184,986
Computed interest (from Exhibit B)	\$200,011
Total	<u>\$468,057</u>
Divided by annualized patient days	<u>/ 40,734*</u>
FRV per diem	<u>\$ 11.49</u>

* Annualized patient days:	
Total facility size	124
Times 365	<u>× 365</u>
Subtotal	<u>45,260</u>
Greater of minimum utilization or facility occupancy	<u>× 90%**</u>
Annualized patient days	<u>40,734</u>

\*\* Assumption: facility occupancy from the rate setting cost report below 90%.

(b) Borrowing costs per diem. A per diem is calculated by dividing the sum of the borrowing costs by the greater of ninety percent (90%) of the total bed days from the rate setting cost report or the facility's patient days from the rate setting cost report. The following is an illustration of how this is calculated:

Borrowing costs (from Ex. B)	\$9,800
Patient Days	<u>/ 39,420*</u>

Borrowing cost/pass through per diem	<u>\$ .25</u>
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\* Patient days—greater of:  
90% of bed days = 120 beds × 365 days × 90% = 39,420  
Facility patient days = 37,890 (Assumption)

(c) The capital per diem is the sum of subparts (11)(A)3.B.(V)(a) and (11)(A)3.B.(V)(b).

FRV per diem	\$11.49
Borrowing cost/pass through per diem	<u>\$ .25</u>
Total capital	<u>\$11.74</u>

The capital cost per-diem rate shall be fixed and will not be adjusted except as may be authorized under section (12) or (13.)

(B) New Facilities.

1. Initial per-diem rates. A new facility shall submit to the division a written request for establishment of an initial per-diem rate. The request shall include all documentation necessary to determine the allowable capital in accordance with procedures described in subparagraph (11)(A)3.B. The initial per-diem rate shall become effective on the date the new facility satisfies all licensing and certification requirements of the Division of Aging for participation in the Medicaid Program as an SNF and any additional requirements of this rule for participation in the pediatric nursing care program. The initial per-diem rate shall be established as the lower of the level-of-care ceiling in effect on the effective date of the initial per-diem rate or the average private pay rate, or the Medicare (Title XVIII) per-diem rate, if applicable.

2. Interim rate. The new facility shall file a cost report in accordance with all applicable requirements of this rule by the first day of the fourth month following the close of the new facility's first full facility fiscal year. Based upon the data contained in the desk-reviewed or field-audited first full facility fiscal year cost report, or both; provided, the reported costs are allowable, covered, properly apportioned, properly allocated and properly classified as prescribed elsewhere in this rule, an interim per-diem rate shall be established. The interim per-diem rate shall be the sum of the patient care per-diem rate and the general and administrative per-diem rate, applying the procedures described in paragraphs (11)(A)1. and 2., plus the capital per-diem rate as originally fixed per subparagraph (11)(A)3.B. The interim rate shall be established retroactive to the first day of the first full facility fiscal year and prospectively up to the July 1 following the last day of the facility's second full facility fiscal year. On the July 1 following the last day of the facility's second full facility fiscal year, the facility



will become eligible for the annual rate determination described in subsection (11)(A). New facilities are eligible for trend factors applied only to the patient care portion of the per-diem rate which may be authorized between the effective date of the interim rate and the date the facility becomes eligible for annual rate determination.

#### (12) Rate Reconsideration.

(A) A provider may request reconsideration of the per-diem rate only under the following circumstances:

1. When the provider can show that it incurred higher costs due to circumstances beyond its control and the circumstances are not experienced by the nursing home industry in general, the request must have a substantial cost effect. These circumstances include, but are not limited to:

A. Acts of nature, such as fire, earthquakes and flood, that are not covered by insurance;

B. Vandalism, civil disorder, or both;

or  
C. Replacement of capital depreciable items not built into the existing rate that are the result of circumstances not related to normal wear and tear or upgrading of existing systems;

2. A provider may request a rate adjustment for replacement beds/facility. The facility must obtain an approved certificate of need or applicable waiver for the replacement beds/facility. The facility shall provide all documentation requested by the division relating to the replacement beds/facility.

A. The capital per diem is calculated for the replacement beds/facility as set forth in subparagraph (11)(A)3.B. using the asset value, rate of return, and interest rate in effect for the date the replacement beds/facility are placed in service. The rate adjustment will be calculated as the difference between the facility's capital per diem prior to the replacement beds/facility being placed in service and the capital per diem including the replacement beds/facility.

B. The rate adjustment will be incorporated into the facility's per-diem rate by replacing its capital per diem prior to the replacement beds with the capital per diem including the replacement beds.

3. A provider may request a rate adjustment additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The facility shall provide all documentation requested by the division relating to the additional beds.

A. The capital per diem is calculated for the additional beds as set forth in subparagraph (11)(A)3.B. using the asset value, rate of return, and interest rate in effect for the

date the additional beds are placed in service. The rate adjustment will be calculated as the difference between the facility's capital per diem prior to the additional beds being placed in service and the capital per diem including the additional beds.

B. The rate adjustment will be incorporated into the facility's per-diem rate by replacing its capital per diem prior to the additional beds with the capital per diem including the additional beds.

4. The request for rate reconsideration must be submitted in writing to the division, must specifically and clearly identify the reason for the request, must include sufficient documentation evidencing that the costs were actually incurred, must be in detail sufficient for the division to determine whether or not the costs were or were not included in the rate, and must include the amount requested;

5. The division will make a recommendation to the director of the Department of Social Services within sixty (60) days following the receipt of all documentation required or necessary, or both, to evaluate the request. The director's or his/her designee's final decision on each request shall be issued in writing to the provider within fifteen (15) working days from receipt of the division's recommendation; and

6. The director's or his/her designee's final determination on the division's recommendation shall become effective on the first day of the month in which the request was made providing that it was made prior to the tenth of the month. If the request is not filed by the tenth of the month, adjustments shall be effective on the first day of the following month.

#### (13) Rate Adjustments.

(A) Unless specifically provided elsewhere in these rules, the division may increase or decrease the per-diem rate both prospectively and retrospectively only under the following conditions:

1. Pursuant to a court decision; or

2. Pursuant to an Administrative Hearing Commission decision or order.

(B) Unless specifically provided elsewhere in these rules, the division may decrease the per-diem reimbursement rate both prospectively and retrospectively only under the following conditions:

1. If the information contained in or attached to a cost report on which a per-diem rate has been based is found to be fraudulent, misrepresented or inaccurate, and if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a higher per-diem rate than the facility would have received in the absence of this information;

2. When the facility's Medicaid per-diem rate is higher than either its private pay rate or its Medicare (Title XVIII) rate; or

3. When a determination through desk audits, field audits and other means establishes that unallowable costs were included in a cost report used to establish the per-diem rate.

(C) Global Per-Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per-diem rate adjustments. Global per-diem rate adjustments shall be added to the level of care ceiling.

1. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on November 1, 1996, shall be granted an increase to their per diem effective November 1, 1996, of two dollars forty-five cents (\$2.45) to allow for the change in federal minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the fifty cent (\$.50) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

2. Minimum wage adjustment. All facilities with either an interim rate or a prospective rate in effect on September 1, 1997, shall be granted an increase to their per diem effective September 1, 1997, of one dollar ninety-eight cents (\$1.98) to allow for the change in minimum wage. Utilizing Fiscal Year 1995 cost report data, the total industry hours reported for each payroll category was multiplied by the forty cent (\$.40) increase, divided by the patient days for the facilities reporting hours for that payroll category and factored up by 8.67% to account for the related increase to payroll taxes. This calculation excludes the director of nursing, the administrator and assistant administrator.

(D) Special Per-Diem Rate Adjustments. Special per-diem rate adjustments may be added to a qualifying facility's rate without regard to the level of care ceiling if specifically provided as described below.

#### 1. Quality Assurance Incentive.

A. Each pediatric nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per-diem adjustment of \$3.20. The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per-diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 45 through 60 and





lines 77 through 85 of Schedule B in the Title XIX Cost Report version MSIR-1 (7-93)). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

(14) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this rule, the division may also impose sanctions against a provider in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulation.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the division in accordance with 13 CSR 70-3.030 Sanctions for False or Fraudulent Claims for Title XIX Services.

(15) Appeals. In accordance with sections 208.156 and 621.055, RSMo, providers may appeal final decisions of the director, Department of Social Services or the Division of Medical Services to the Administrative Hearing Commission.

(16) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this rule for those facilities with Medicaid participation agreements in effect on June 30, 1989, which also qualify on July 1, 1990, for participation in the pediatric nursing care program.

**APPENDIX A**

- ABD Pads
- A & D Ointment
- Adhesive Tape
- Aerosol Inhalators, Self-Contained
- Aerosol, Other Types
- Air Mattresses
- Air P.R. Mattresses
- Airway—Oral
- Alcohol
- Alcohol Plasters
- Alcohol Sponges
- Alternating Pressure Pads
- Antacids, Nonlegend
- Applicators, Cotton-Tipped
- Applicators, Swab-Eez
- Aquamatic K Pads (water-heated pad)
- Arm Slings
- Asepto Syringes
- Baby Powder
- Bandages
- Bandages (elastic or cohesive)
- Band-aids
- Basins

- Bed Frame Equipment (for certain immobilized bed patients)
- Bed Rails
- Bedpans (all types)
- Beds, Manual, Electric, Clinitron
- Bedside Tissues
- Benzoin
- Betadine
- Bibs
- Blood Infusion Sets
- Bottle, Specimen
- Canes (all types)
- Cannula—Nasal
- Catheter Indwelling
- Catheter Plugs
- Catheter Trays
- Catheter (any size)
- Colostomy Bags
- Combs
- Commodes (all types)
- Composite Pads
- Cotton Balls
- Crutches (all types)
- Decubitus* Ulcer Pads/Dressings
- Denture Cleaner/Soak
- Denture Cups
- Deodorants
- Diapers
- Disposable Underpads
- Donuts
- Douche Bags
- Drain Tubing
- Drainage Bags
- Drainage Sets
- Drainage Tubes
- Dressing Tray
- Dressings (all types)
- Drugs, Stock (excluding Insulin)
- Enema Soap
- Enema Supplies
- Enema Unit
- Equipment and Supplies for Diabetic Blood and Urine Testing
- Eye Pads
- Feeding Tubes
- Fingernail Clipping and Cleaning
- Flotation Mattress or Biowave Mattress
- Flotation Pads, Turning Frames, or both
- Foot Cradle (all types)
- Gastric Feeding Unit (including bags)
- Gauze Sponges
- Gloves, Unsterile and Sterile
- Gowns, Hospital
- Green Soap
- Hairbrushes
- Hair Care, Basic
- Hand-Feeding
- Heat Cradle
- Heating Pads
- Heel Protector
- Hot Pack Machine
- Hydraulic Patient Lifts
- Hypothermia Blanket

- Ice Bags
- Incontinency Care
- Incontinency Pads and Pants
- Infusion Arm Boards
- Infusion Pumps, Enteral and Parenteral
- Inhalation Therapy Supplies
- Irrigation Bulbs
- Irrigation Trays
- I.V. Needles
- I.V. Trays
- I.V. Tubing
- Jelly—Lubricating
- Laxatives, Nonlegend
- Lines, Extra
- Lotion, Soap and Oil
- Massages (by facility personnel)
- Mattresses (all types)
- Medical Social Services
- Medicine Cups
- Medicine Dropper
- Merthiolate Aerosol
- Mouthwashes
- Nasal Catheter
- Nasal Catheter, Insertion and Tube
- Nasal Gastric Tubes
- Nasal Tube Feeding and Feeding Bags
- Nebulizer and Replacement Kit
- Needles (hypodermic, scalp, vein)
- Needles (various sizes)
- Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
- Nursing Supplies and Dressing
- Ostomy Supplies (adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures)
- Overhead Trapeze Equipment
- Oxygen, Gaseous and Liquid
- Oxygen Concentrators
- Oxygen Delivery Systems, Portable or Stationary
- Oxygen Mask
- Pads
- Peroxide
- Pitcher
- Plastic Bib
- Pump (aspiration and suction)
- Pumps for Alternating Pressure Pads
- Respiratory Equipment (Ambu Bags, cannulas, compressors, humidifiers, IPPB Machines and circuits, mouth pieces, nebulizers, suction catheters, suction pumps, tubing)
- Restraints
- Room and Board (semiprivate or private if necessitated by a medical or social condition)
- Sand Bags
- Scalpel
- Shampoo



Shaves  
 Shaving Cream  
 Sheepskin  
 Side Rails  
 Soap  
 Special Diets  
 Specimen Cups  
 Sponges  
 Steam Vaporizer  
 Sterile Pads  
 Sterile Saline for Irrigation  
 Sterile Water for Irrigation  
 Stomach Tubes  
 Stool Softeners, Nonlegend  
 Suction Catheter  
 Suction Machines  
 Suction Tube Surgical Dressings (including sterile sponges)  
 Surgical Pads  
 Surgical Tape  
 Suture Removal Kit  
 Suture Trays  
 Syringes (all sizes)  
 Syringes, Disposable  
 Tape (for laboratory tests)  
 Tape (nonallergic or butterfly)  
 Testing Sets and Refills (S & A)  
 Therapy Services  
 Toenail Clipping and Cleaning  
 Tongue Depressors  
 Toothbrushes  
 Toothpaste  
 Tracheostomy Sponges  
 Trapeze Bars  
 Tray Service  
 Underpads  
 Urinals, Male and Female  
 Urinary Drainage Tube  
 Urinary Tube and Bottle  
 Urological Solutions  
 Vitamins, Nonlegend  
 Walkers (all types)  
 Water Circulating Pads  
 Water Pitchers  
 Wheelchairs (amputee, geriatric, heavy duty, hemi, lightweight, one-arm drive, reclining, rollabout, semireclining, standard)

#### APPENDIX B

##### Noncovered Supplies, Items and Services

Audiology Services  
 Barber and Beauty Shop Services  
 Cigarettes, Cigars, Pipes and Tobacco  
 Clothing  
 Cosmetics  
 Dental Services  
 Dry Cleaning  
 Eye Examinations  
 Eye Glasses  
 Hearing Aids  
 Home Parenteral Nutrition/Total Parenteral Nutrition Solutions, Additives, Supplies

Hospital Services  
 Laboratory Services  
 Optical Services  
 Orthotic Devices  
 Pharmacy  
 Physician  
 Podiatry Services  
 Prosthetic Devices  
 Ventilators  
 Wheelchair Batteries  
 Wheelchairs, Customized (chairs that are fitted/fabricated to a specific individual that cannot be used by any other person)  
 Wheelchairs, Electric

#### APPENDIX C

Year	Asset Value
1994	\$ 32,330
1995	\$ 32,723
1996	\$ 32,921
1997	\$ 33,355
1998	\$ 33,829
1999	\$ 34,205
2000	\$ 34,797

*AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 2000.\* Original rule filed Sept. 26, 1989, effective Feb. 11, 1990. Emergency amendment filed Oct. 5, 1992, effective Nov. 1, 1992, expired Feb. 28, 1993. Emergency amendment filed Feb. 16, 1993, effective Feb. 28, 1993, expired June 27, 1993. Amended: Filed Oct. 5, 1992, effective May 6, 1993. Amended: Filed Oct. 16, 1995, effective May 30, 1996. Emergency amendment filed Oct. 15, 1996, effective Oct. 25, 1996, expired April 22, 1997. Emergency amendment filed Oct. 22, 1996, effective Nov. 1, 1996, expired April 29, 1997. Emergency amendment filed Aug. 12, 1997, effective Sept. 1, 1997, expired Feb. 27, 1998. Amended: Filed Aug. 12, 1997, effective Feb. 28, 1998. Amended: Filed May 27, 1999, effective Nov. 30, 1999. Emergency amendment filed, Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Emergency amendment filed July 18, 2000, effective July 28, 2000, expired Jan. 24, 2001. Amended: Filed June 30, 2000, effective Feb. 28, 2001. Amended: Filed Nov. 15, 2001, effective May 30, 2002.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1987.*

#### 13 CSR 70-10.060 Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services

*PURPOSE: This rule establishes a payment plan for state-operated providers of services required by the Code of Federal Regulations.*

*The plan describes principles to be followed by Title XIX intermediate care facility/mentally retarded providers in making financial reports and presents the necessary procedures for setting rates, making adjustments and auditing the cost reports.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material. The forms mentioned in this rule follow 13 CSR 70-10.010.*

(1) Objectives. The retrospective rate plan described in this rule shall apply to state-operated intermediate care facility/mentally retarded (ICF/MR) facilities for dates of service on and after March 1, 1990, and the objective of this plan is to provide reimbursement of allowable cost.

(2) General Principles. The Missouri Medical Assistance program shall reimburse qualified providers of ICF/MR services based solely on the individual MO HealthNet participant's days of care (within benefit limitations) multiplied by the facility's Title XIX per diem rate less any payments made by participants as described in sections (4) and (5).

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the MO HealthNet program based upon the principles established in this plan. The allowability of cost areas not specifically addressed in this plan will be based upon criteria of the *Medicare Provider Reimbursement Manual (HIM-15)* and section (7) of this rule.

(B) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(C) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(D) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(E) Division. The division, unless otherwise specified, refers to the MO HealthNet



Division.

(F) Effective date. The plan effective date shall be for services furnished on and after March 1, 1990.

(G) ICF/MR. State-operated facilities certified to provide intermediate care for the mentally retarded under the Title XIX program.

(H) Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement (42 CFR part 405).

(I) New construction. Newly built facilities or parts for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after March 1, 1990.

(J) Patient days. Patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (6) of this rule, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

(K) Providers. A provider under the Retrospective Reimbursement Plan is a state-operated ICF/MR facility with a valid participation agreement in effect on or after February 28, 1990, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants.

(L) Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility.

**(4) Interim Rate.**

(A) For service dates beginning March 1, 1990 through and including June 30, 1991, each provider shall be assigned an interim per diem rate for reimbursement under the Missouri Medicaid program. The interim per diem rate will be based on the provider's fiscal year FY-89 desk-reviewed allowable costs inflated forward on the basis of the historical rate of change. This rate of change shall be thirty-five percent (35%) of the following amount: the percentage increase between the FY-87 weighted mean allowable cost per patient day for all state-operated facilities (WMACPPDSOF) and the FY-89 WMACPPDSOF annualized by dividing by two (2).

**Example**

FY-87 WMACPPDSOF \$128.06

FY-89 WMACPPDSOF \$161.47

Percent of Change

$$(\$161.47 - \$128.06) \div \$128.06 = 26.09\%$$

Annualized Percent of Change

$$(26.09\% \div 2) = 13.04\%$$

35% of Annualized Percent of Change

$$(13.04\% \times 35\%) = 4.57\%$$

Facility FY-89 Allowable Cost

\$24,220,500

Facility FY-89 Patient Days 150,000

Inflated Cost

$$(\$24,220,500 \times 104.57\%) = \$25,327,376$$

Interim Rate

$$(\$25,327,376 \div 150,000) = \$168.85$$

(B) For service dates beginning July 1, 1991 and annually after that, each provider shall be assigned an interim per-diem rate based on the provider's second prior year desk-reviewed allowable costs inflated forward on the basis of the historical rate of change. This rate of change shall be fifty percent (50%) of the following amount: the percentage increase between the fourth prior year WMACPPDSOF and the second prior year WMACPPDSOF annualized by dividing by two (2). For example with the July 1, 1991 interim rate, the fourth prior year is the facility fiscal year ending June 30, 1988, and the second prior year is the facility fiscal year ending June 30, 1990.

**Example**

FY-88 WMACPPDSOF \$160

FY-90 WMACPPDSOF \$180

Percent of Change

$$(\$180 - \$160) \div \$160 = 12.50\%$$

Annualized Percent of Change

$$(\$12.50 \div 2) = 6.25\%$$

50% of Annualized Percent of Change

$$(6.25\% \times 50\%) = 3.13\%$$

Facility FY-90 Allowable Cost

\$27,000,000

Facility FY-90 Patient Days 150,000

Inflated Cost

$$(\$27,000,000 \times 103.13\%) = \$27,845,100$$

Interim Rate

$$(\$27,845,100 \div 150,000) = \$185.63$$

(C) In the case of newly constructed state-operated ICF/MR facilities or existing facilities not previously certified to participate in the Title XIX Program entering the MO HealthNet Program after February 28, 1990, the facilities shall have an interim rate based on one hundred twenty-five percent (125%) of the weighted mean rate of all providers for the month prior to entering the MO HealthNet program until the time a second prior year cost report is available, at which time the provisions of subsection (4)(B) will apply.

**Example**

Weighted Mean Rate of All Providers

(7/01/91) \$160

Interim Rate Effective (8/01/91)

$$(\$160 \times 125\%) = \$200$$

(D) When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's interim rate at the discretion of the division may be both retroactively and prospectively adjusted if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a different interim rate than the facility would have received in the absence of that information.

**(5) Retroactive Adjustments.**

(A) The division shall desk review the MO HealthNet cost reports for each facility and shall determine the facility's allowable cost per patient day. This shall be the final per diem rate for the service dates covered by the cost report. A payment adjustment will be made equal to the difference between the final per diem rate and the interim per diem rate multiplied by the MO HealthNet days corresponding to the service dates covered by the interim per diem rate. For the period March 1, 1990 through June 30, 1990, the full facility Fiscal Year 1990 Medicaid cost report will be used to establish the final per diem rate for payment adjustment purposes.

(B) When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's final rate at the discretion of the division may be both retroactively and prospectively adjusted if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a different final rate than the facility would have received in the absence of that information.

(6) Covered Services and Supplies. ICF/MR services and supplies covered by the per diem reimbursement rate under this rule, and which must be provided, are found in 42 CFR 442.100-442.516 and include, among other services, the regular room, dietary and nursing services or any other services that are required for standards of participation or certification, also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

(A) All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service and enemas;

(B) Items which are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins and bed pans;

(C) Items such as alcohol, applicators, cotton balls, bandaids and tongue depressors;

(D) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. All nonlegend drugs in one (1) of these four (4) categories must be provided



to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per-diem rate;

(E) Items which are utilized by individual participants but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, nondepreciable medical equipment;

(F) Additional items as specified in the appendix to this plan when required by the patient;

(G) Special dietary supplements used for tube feeding or oral feeding such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

(H) All laundry services including personal laundry;

(I) All general personal care services which are furnished routinely and relatively uniformly to all participants for their personal cleanliness and appearance shall be covered services; for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

(J) All consultative services as required by state or federal law or rule or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this rule;

(K) Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service and a MO HealthNet participant or responsible party may pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

(L) Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. These temporary leave of

absence days specifically must be provided for in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

(M) Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

#### (7) Allowable Cost Areas.

(A) Covered Services and Supplies as Defined in Section (6) of This Plan.

##### (B) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets shall be the lower of the book value of the provider, fair market value at the time of acquisition or the recognized Internal Revenue Service (IRS) tax basis. Donated assets will be allowed basis to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

4. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this rule.

5. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation

purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars (\$500) or having a useful life of one (1) year or less may be expensed and not capitalized at the option of the provider.

6. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of undepreciated cost basis of the traded asset plus the cash paid.

7. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if the capital expenditures have not received approved CON or waiver.

8. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

##### (C) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short-term. This is usually for purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes such as acquisition of facilities and capital improvements and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims and necessary and proper for the operation, maintenance or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans which result in excess funds or investments are not considered necessary.



6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

8. A provider shall amortize finance charges, prepaid interest and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

9. Usual and customary costs excluding finder's fees incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

10. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees and closing costs.

11. Interest expense resulting from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars (\$150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the expenditure fails to comply with other federal or state requirements that promulgate a limitation on reimbursement for capital expenditures, such as CON.

(D) Rental and Leases.

1. Rental and leases of land, buildings, furnishings and equipment are allowable cost areas; provided, that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and lease amounts, except in the case of related parties which is subject to other provisions of this plan, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must

have that approval before a rate is determined.

(E) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing or refunding operations such as taxes on the issuance of bond, property transfer, issuance or transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which is not a part of the operation of the provider; and

6. Taxes which are levied against a resident and collected and remitted by the provider.

(F) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals and similar organizations, shall not be included as an allowable cost area, as the services traditionally have been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis and similar type professionals shall be an allowable cost area, provided that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(G) Fringe Benefits.

1. Life insurance.

2. Retirement plans. Contributions to qualified retirement plans, as determined by the United States IRS, for the benefit of employees of the provider shall be allowable cost area.

(H) Education and Training Expenses.

1. The cost of training which directly benefits the quality of health care or adminis-

tration at the facility shall be allowable.

2. Cost of education and training shall include travel costs incidental to training but will not include leaves of absence or sabbaticals.

(I) Advertising Costs. Advertising costs which are reasonable, appropriate and helpful in developing, maintaining and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(J) Central Office and State Central Service Costs. Costs which are appropriately distributed to the provider as direct costs, properly allocated to the provider, or allocated in accordance with approved cost allocation plans when plans are required, shall be allowable.

(K) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX participants. Utilization review costs incurred for Title XVIII and XIX must be apportioned on the basis of reimbursable participant days recorded for each program during the reporting period.

(L) Minimum Utilization. In the event the occupancy utilization of a provider is below ninety percent (90%) of its certified bed capacity, appropriate adjustments shall be made to the allowable cost areas of the provider. Fixed costs will be calculated as if the provider experienced ninety percent (90%) utilization. The fixed costs are laundry, housekeeping, general and administrative and plant operation costs. Variable costs will be calculated at actual utilization. The variable costs are nursing, dietary and ancillary costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(M) Nonreimbursable Costs.

1. Bad debts, charity and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

(N) Other Revenues. Other revenues, including those listed that follow, will be deducted from the total allowable cost, and must be shown separately in the cost report by use of a separate schedule if included in



the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time and other discounts; purchase rebates and refunds; parking lot revenues; vending machine commission or profit; sales from drugs to other than participants; Medicare Part B revenues; and room reservation charges for temporary leave of absence days which are not covered services under section (6) of this rule. Failure to separately account for any of the revenues specifically set out previously in this rule in a readily ascertainable manner shall result in termination from the program.

(O) Apportionment of Costs to MO HealthNet Participant Residents. Provider's allowable cost areas shall be apportioned between the certified ICF/MR portion and the noncertified portion so that the share borne by the MO HealthNet program is based upon actual services received by program participants.

#### (8) Reporting Requirements.

##### (A) Annual Cost Report.

1. Each provider shall establish a twelve (12)-month period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed forms shall be submitted by each provider within ninety (90) days following the close of its fiscal year.

2. Unless adequate and current documentation in the following areas have previously been filed with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility, all management contracts and all contracts with consultants.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. Following the ninety (90)-day period, payments will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with these rules, the payments that were withheld will be released.

5. If requested in writing, a thirty (30)-day extension of the filing date may be granted for good cause shown.

6. The termination of or by a provider of participation in the program requires that the provider submit a cost report for the period ending with the date of termination. The cost report is due within forty-five (45) days of the date of termination. Cost reports under this paragraph shall conform to the principles of section (7). The final payment due providers

shall be withheld until their cost report is filed.

7. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

8. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents.

9. The department shall retain the annual cost report and any working papers relating to the audits of the cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

##### (B) Certification of Cost Reports.

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report also must be notarized by a licensed notary public.

##### 2. Certification statement.

###### Form of Certification

Misrepresentation or falsification of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared by \_\_\_\_\_

(Provider name(s) and number(s))

for the cost report period beginning \_\_\_\_\_, 19\_\_ and ending \_\_\_\_\_, 19\_\_ and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)

##### (C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from the Department of Health and Human Services (HHS), at all reasonable times, records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions stated in paragraph (8)(A)4. of this rule or other sanctions available in section (9).

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

##### (D) Accounting Basis.

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

##### (9) Sanctions and Overpayments.

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

##### (10) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in these rules.

(B) Where third-party payment is involved, MO HealthNet will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the Missouri Medical Assistance (MO HealthNet) Program provider manuals.

(11) Provider Participation. Payments made in accordance with the standards and methods described in this rule are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(12) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with these rules and applicable copayments.

(13) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

(14) Transition. Cost reports used for the determination of the rates and the historical



rate of change shall be adjusted by the division in accordance with the cost principles provided in this plan.

**APPENDIX A  
Routine Covered Medical Supplies  
and Services**

ABD Pads  
A & D Ointment  
Adhesive Tape  
Aerosol Inhalators, Self-Contained  
Aerosol, Other Types  
Air Mattresses  
Air P.R. Mattresses  
Airway—Oral  
Alcohol  
Alcohol Plasters  
Alcohol Sponges  
Antacids, Nonlegend  
Applicators, Cotton-Tipped  
Applicators, Swab-Eez  
Aquamatic K Pads (water-heated pad)  
Arm Slings  
Asepto Syringes  
Baby Powder  
Bandages  
Bandages (elastic or cohesive)  
Band-aids  
Basins  
Bed Frame Equipment (for certain immobilized bed patients)  
Bed Rails  
Bedpan, Fracture  
Bedpan, Regular  
Bedside Tissues  
Benzoin  
Bibs  
Bottle, Specimen  
Canes  
Cannula—Nasal  
Catheter Indwelling  
Catheter Plugs  
Catheter Trays  
Catheter (any size)  
Colostomy Bags  
Composite Pads  
Cotton Balls  
Crutches  
Customized Crutches, Canes and Wheelchairs  
Decubitus Ulcer Pads  
Deodorants  
Disposable Underpads  
Donuts  
Douche Bags  
Drain Tubing  
Drainage Bags  
Drainage Sets  
Drainage Tubes  
Dressing Tray  
Dressings (all)  
Drugs, Stock (excluding Insulin)  
Enema Can  
Enema Soap

Enema Supplies  
Enema Unit  
Enemas  
Equipment and Supplies for Diabetic Urine Testing  
Eye Pads  
Feeding Tubes  
Female Urinal  
Flotation Mattress or Biowave Mattress  
Flotation Pads, Turning Frames, or both  
Folding Foot Cradle  
Gastric Feeding Unit  
Gauze Sponges  
Gloves, Unsterile and Sterile  
Gowns, Hospital  
Green Soap  
Hand-Feeding  
Heat Cradle  
Heating Pads  
Heel Protector  
Hot Pack Machine  
Ice Bags  
Incontinency Care  
Incontinency Pads and Pants  
Infusion Arm Boards  
Inhalation Therapy Supplies  
Intermittent Positive Pressure Breathing Machine (IPPB)  
Invalid Ring  
Irrigation Bulbs  
Irrigation Trays  
I.V. Trays  
Jelly—Lubricating  
Laxatives, Nonlegend  
Lines, Extra  
Lotion, Soap and Oil  
Male Urinal  
Massages (by nurses)  
Medical Social Services  
Medicine Cups  
Medicine Dropper  
Merthiolate Aerosol  
Mouthwashes  
Nasal Cannula  
Nasal Catheter  
Nasal Catheter, Insertion and Tube  
Nasal Gastric Tubes  
Nasal Tube Feeding  
Nebulizer and Replacement Kit  
Needles (hypodermic, scalp, vein)  
Needles (various sizes)  
Nonallergic Tape  
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care  
Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)  
Overhead Trapeze Equipment  
Oxygen Equipment (such as IPPB machines and oxygen tents)  
Oxygen Mask  
Pads  
Peroxide  
Pitcher

Plastic Bib  
Pump (aspiration and suction)  
Restraints  
Room and Board (semiprivate or private if necessitated by a medical or social condition)  
Sand Bags  
Scalpel  
Sheepskin  
Special Diets  
Specimen Cups  
Sponges  
Steam Vaporizer  
Sterile Pads  
Stomach Tubes  
Stool Softeners, Nonlegend  
Suction Catheter  
Suction Machines  
Suction Tube  
Surgical Dressings (including sterile sponges)  
Surgical Pads  
Surgical Tape  
Suture Removal Kit  
Suture Trays  
Syringes (all sizes)  
Syringes, Disposable  
Tape (for laboratory tests)  
Tape (nonallergic or butterfly)  
Testing Sets and Refills (S & A)  
Tongue Depressors  
Tracheostomy Sponges  
Tray Service  
Tubing I.V. Trays, Blood Infusion Set, I.V. Tubing  
Underpads  
Urinary Drainage Tube  
Urinary Tube and Bottle  
Urological Solutions  
Vitamins, Nonlegend  
Walkers  
Water Pitchers  
Wheelchairs

*AUTHORITY: sections 208.159, RSMo 2000 and 208.153 and 208.201, RSMo Supp. 2007.\* Original rule filed March 5, 1990, effective June 11, 1990. Amended: Filed Dec. 14, 1992, effective June 7, 1993. Amended: Filed Aug. 15, 2007, effective March 30, 2008.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.*

**13 CSR 70-10.070 Limitations on Allowable Nursing Facility Costs to Reserve a Bed for Absences Due to Hospital Admission**

*PURPOSE: This rule outlines the coverage of nursing facility costs to reserve a bed in a nursing facility during an absence from the facility due to a hospital admission of three*



days or less and the limitations related to that coverage.

(1) Payment to a nursing facility (NF) for hospital leave days is authorized for days in which a Medicaid recipient is absent from the NF due to admission to a hospital for services which cannot be performed on an outpatient basis, subject to the following:

(A) The nursing facility in which the Medicaid resident resides is licensed under Chapter 198, RSMo;

(B) The NF is in compliance with all federal and state certification standards;

(C) The occupancy rate of the NF is at or above ninety-seven point zero percent (97.0%), rounded to four (4) decimal places, of Medicaid certified licensed beds, for the quarter prior to the first day of services provided based on the census for that quarter provided from the Division of Aging to the Division of Medical Services;

(D) The Medicaid recipient is admitted to a hospital for a medical condition, which cannot be treated on an outpatient basis, with a total stay of three (3) days or less; and

(E) The hospital provides a discharge plan for the recipient which includes returning to the facility requesting the hospital leave days.

(2) The payment for hospital leave days shall only be provided for qualified hospital stays of three (3) days or less. A qualified hospital stay is one in which the medical condition cannot be treated on an outpatient basis.

(3) The hospital leave days billed by the nursing facility shall be held in suspense until the nursing home bill, hospital bill and quarterly census has been received by the Division of Medical Services so appropriate payment can be determined.

(4) Payment for authorized hospital leave days shall be at the per-diem rate for the respective provider.

(5) For each day that Medicaid reimburses a nursing facility, pursuant to this subsection, the Medicaid recipient shall be ineligible for reimbursement to nursing facilities for two otherwise available temporary leave of absence days as described in 13 CSR 70-10.010(5)(D). The total hospital leave days and temporary leave of absence days shall not exceed the limits for the periods defined in 13 CSR 70-10.010(5)(D).

*AUTHORITY: sections 208.153, RSMo Supp. 1991, 208.159, RSMo 1986 and 208.201, RSMo Supp. 1987.\* Emergency rule filed Dec. 17, 1993, effective Dec. 27, 1993, expired April 25, 1994. Emergency rule filed April 15, 1994, effective May 1, 1994,*

*expired Aug. 28, 1994. Original rule filed Nov. 2, 1993, effective June 6, 1994.*

*\*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1987.*

### 13 CSR 70-10.080 Prospective Reimbursement Plan for HIV Nursing Facility Services

*PURPOSE: This rule establishes a payment plan for HIV nursing facility services. The plan describes principles to be followed by Title XIX HIV nursing facility providers in making financial reports and presents the necessary procedures for setting rates, making adjustments, and auditing the cost reports.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*

(1) Authority. This regulation is established pursuant to the authorization granted to the Department of Social Services (department), MO HealthNet Division (division), to promulgate rules and regulations.

(2) Purpose. This regulation establishes a methodology for determination of reimbursement rates for human immunodeficiency virus (HIV) nursing facilities, operated exclusively for persons with HIV that causes acquired immunodeficiency syndrome (AIDS). Subject to limitations prescribed elsewhere in this regulation, a facility's reimbursement rate shall be determined by the division as described in this regulation. Any reimbursement rate determined by the division shall be a final decision and will be implemented as set forth in the division's decision letter. The decisions of the division may be subject to review upon properly filing a complaint with the Administrative Hearing Commission (AHC). A nursing facility seeking review by the AHC must obtain a stay from the AHC to stop the division from implementing its final decision if the AHC determines the facility meets the criteria for a stay and so orders. If the facility appeals the division's decision, it is the responsibility of the nursing facility to notify any interested parties, including but not limited to hospice

providers, that the rate being received is not a final rate and is subject to change. Federal financial participation is available on expenditures for services provided within the scope of the Federal Medicaid Program and made under a court order in accordance with 42 CFR 431.250.

(3) General Principles.

(A) Provisions of this reimbursement regulation shall apply only to HIV nursing facilities certified for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement rates determined by this regulation shall apply only to services for HIV residents provided on or after December 1, 1995.

(C) The effective date of this regulation shall be December 1, 1995.

(D) The Medicaid Program shall provide reimbursement for HIV nursing facility services based solely on the individual Medicaid-eligible recipient's covered days of care, within benefit limitations as determined in subsections (5)(D) and (5)(M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this plan. Where third-party payment is involved, Medicaid will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services.

(E) The Medicaid reimbursement rate shall be the lower of:

1. The Medicare (Title XVIII) rate, if applicable; or

2. The reimbursement rate as determined in accordance with sections (11), (12), and (13) of this rule.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(G) When an HIV nursing facility is found not in compliance with federal requirements for participation in the Medicaid Program, sections 1919(b), (c), and (d) of the Social Security Act (42 U.S.C. 1396r), it may be terminated from the Medicaid Program or it may have imposed upon it an alternative remedy, pursuant to section 1919(h) of the Social Security Act (42 U.S.C. 1396r). In accordance with section 1919(h)(3)(D) of the Social Security Act, the alternative remedy, denial of payment for new admission, is contingent upon agreement to repay payments received if the corrective action is not taken





in accordance with the approved plan and timetable. It is also required that the HIV nursing facility establish a directed plan of correction in conjunction with and acceptable to the Division of Aging.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid Program shall be assigned a provider number by the division. Facilities previously certified shall retain the same provider number and interim or prospective rate regardless of any change in ownership.

(I) Regardless of changes in control or ownership for any facility certified for participation in the Medicaid Program, the division shall issue payments to the facility identified in the current Medicaid participation agreement. Regardless of changes in control or ownership for any facility certified for participation in Medicaid, the division shall recover from the entity identified in the current Medicaid participation agreement, liabilities, sanctions, and penalties pertaining to the Medicaid Program, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement.

(K) A facility with certified and noncertified beds shall allocate allowable costs related to the provision of HIV nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data necessary to evaluate the allocation method and its application.

(L) Any facility which is involuntarily terminated from participation in the Medicare Program shall also be terminated from participation in the Medicaid Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state regulation, be placed on a recipient's right to select providers of his/her own choice.

(N) Rebased. Effective July 1, 2004, HIV nursing facility rates shall be rebased on an annual basis, as set forth in section (20).

(O) The reimbursement rates authorized by this regulation may be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as, but not limited to, food, laundry supplies, housekeeping

supplies, linens, medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid-eligible resident while placed in a noncertified bed in an HIV nursing facility.

(R) All illustrations and examples provided throughout this regulation are for illustration purposes only and are not meant to be actual calculations.

(S) Each state fiscal year the department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by HIV nursing facilities during the course of one (1) year. The submission of the budget item by the department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary, and administration cost components.

(T) Effective for dates of service beginning April 1, 2010, reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits in an HIV nursing facility shall be as follows:

1. Crossover claims for Medicare Part A inpatient skilled nursing facility benefits in which Medicare was the primary payer and the MO HealthNet Division is the payer of last resort for the coinsurance must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Part A inpatient skilled nursing facility benefits that were provided to MO HealthNet participants also having Medicare coverage; and

B. The crossover claim must contain approved coinsurance days. The amount indicated by Medicare to be the coinsurance due on the Medicare allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which Medicare is not the sole payer. These days are referred to as coinsurance days and are days twenty-one (21) through one hundred (100) of each

Medicare benefit period; and

C. The Other Payer paid amount field on the claim must contain the actual amount paid by Medicare. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Part A inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the claim upon request. The documentation must match the information on the Medicare Part A plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

D. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by Medicare for the same approved coinsurance days;

2. Crossover claims for Medicare Advantage/Part C (Medicare Advantage) inpatient skilled nursing facility benefits in which a Medicare Advantage plan was the primary payer and the MO HealthNet Division is the payer of last resort for the copay (coinsurance) must meet the following criteria to be eligible for MO HealthNet reimbursement:

A. The crossover claim must be related to Medicare Advantage inpatient skilled nursing facility benefits that were provided to MO HealthNet participants who also are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus); and

B. The crossover claim must be submitted as a Medicare UB-04 Part C Institutional Crossover claim through the division's online Internet billing system; and

C. The crossover claim must contain approved coinsurance days. The amount indicated by the Medicare Advantage plan to be the coinsurance due on the Medicare Advantage plan allowed amount is the crossover amount eligible for MO HealthNet reimbursement. The coinsurance amount is based on the days for which the Medicare Advantage plan is not the sole payer. These days are referred to as coinsurance days and are established by each Medicare Advantage plan; and

D. The Other Payer paid amount field on the claim must contain the actual amount paid by the Medicare Advantage plan. The MO HealthNet provider is responsible for accurate and valid reporting of crossover claims submitted to MO HealthNet for payment. Providers submitting crossover claims for Medicare Advantage inpatient skilled nursing facility benefits to the MO HealthNet program must be able to provide documentation that supports the information on the



claim upon request. The documentation must match the information on the Medicare Advantage plan's remittance advice. Any amounts paid by MO HealthNet that are determined to be based on inaccurate data will be subject to recoupment; and

E. The nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days exceeds the amount paid by the Medicare Advantage plan for the same approved coinsurance days;

3. MO HealthNet reimbursement will be the lower of—

A. The difference between the nursing facility's Medicaid reimbursement rate multiplied by the approved coinsurance days and the amount paid by either Medicare or the Medicare Advantage plan for those same coinsurance days; or

B. The coinsurance amount; and

4. HIV nursing facility providers may not submit a MO HealthNet fee-for-service nursing facility claim for the same dates of service on the crossover claim for Medicare Part A and Medicare Advantage inpatient skilled nursing facility benefits. If it is determined that a MO HealthNet fee-for-service nursing facility claim is submitted and payment is made, it will be subject to recoupment.

#### (4) Definitions.

(A) Additional beds. Newly constructed beds never certified for Medicaid or never previously licensed by the Division of Aging.

(B) Administration. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 111-131, 133-149, 151-158.

(C) Age of beds. The age is determined by subtracting the initial licensing year from 1995 or the current year, if later.

(D) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this regulation. The allowability of costs shall be determined by the Division of Medical Services and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (HIM-15) and Generally Accepted Accounting Principles (GAAP). Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* (HIM-15) as the second source and GAAP as the third source.

(E) Ancillary. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 71-89, 91-100.

(F) Asset value. The asset value is thirty-two thousand seven hundred twenty-three dollars (\$32,723) and is used in calculating the fair rental value system.

(G) Average private pay rate. The usual and customary charge for private patient determined by dividing total private patient days of care into private patient revenue net of contractual allowances and bad debt expense for the same service that is included in the Medicaid reimbursement rate. This excludes negotiated payment methodologies with state or federal agencies such as the veteran's administration or the Missouri Department of Mental Health.

(H) Capital. This cost component will be calculated using a fair rental value system. The fair rental value is reimbursed in lieu of the costs reported on lines 102-109 of the cost report version MSIR-1 (3-95) except for amortization of organizational costs.

(I) Capital asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in HIM-15. Motor vehicles are excluded from this definition.

(J) Capital asset debt. The debt related to the capital assets as determined from the desk audited and/or field audited cost report.

(K) Ceiling. The ceiling is determined by applying a percentage to the median per diem for the patient care, ancillary and administration cost components. The percentage is one hundred twenty percent (120%) for patient care, one hundred twenty percent (120%) for ancillary and one hundred ten percent (110%) for administration.

(L) Certified bed. Any HIV nursing facility bed that is certified by the Division of Aging to participate in the Medicaid Program.

(M) Change of ownership. A change in ownership, control, operator or leasehold interest, for any facility certified for participation in the Medicaid Program.

(N) Cost components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital, and administration. In addition, a working capital allowance is provided.

(O) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10)(A)8. of this regulation and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with this regulation, cost report instruction and on forms or diskettes provided by or as approved by the division or both.

(P) Data bank. The data from the desk audited and/or field audited rate setting cost report for HIV nursing facilities.

(Q) Department. The department, unless otherwise specified, refers to the Missouri

Department of Social Services.

(R) Desk audit. The Division of Medical Services' or its authorized agent's audit of a provider's cost report without a field audit.

(S) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(T) Division of Aging. The division of the Department of Social Services responsible for survey, certification, and licensure as prescribed in Chapter 198, RSMo.

(U) Division. Unless otherwise specified, division refers to the MO HealthNet Division, the division of the Department of Social Services charged with administration of Missouri's MO HealthNet Program.

(V) Entity. Any natural person, corporation, business, partnership or any other fiduciary unit.

(W) Facility asset value. Total asset value less adjustment for age of beds.

(X) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(Y) Facility size. The number of licensed HIV nursing facility beds as determined from the desk audited and/or field audited cost report.

(Z) Fair rental value system (FRVS). The methodology used to calculate the reimbursement of capital.

(AA) Field audit. An on-site audit of the HIV nursing facility's records performed by the department or its authorized agent.

(BB) Generally Accepted Accounting Principles (GAAP). Accounting conventions, practices, methods, rules, and procedures necessary to describe accepted accounting practice at a particular time as established by the authoritative body establishing such principles.

(CC) HCFA Market Basket Index. An index showing nursing home market basket indexes. The index is published quarterly by DRI/McGraw Hill. The table used in this regulation is titled "DRI Health Care Cost—National Forecasts, HFCA Nursing Home Without Capital Market Basket."

(DD) HIV nursing facility. Any facility licensed under Chapter 198, RSMo granted an exemption from Certificate of Need under section 197.316, RSMo and certified by the Division of Aging.

(EE) HIV nursing facility resident. A person that resides in a HIV nursing facility that has the HIV that causes AIDS.

(FF) Interim rate. The interim rate shall be based upon the budgeted cost report (version MSIR-1 (3-95)) that has been submitted to the division. The interim rate shall be the sum of one hundred percent (100%) of the budgeted patient care costs, ninety percent



(90%) of the budgeted ancillary costs and administration costs, ninety-five percent (95%) of the capital cost, and the working capital allowance using the interim rate cost components.

(GG) Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Division of Aging.

(HH) Median. The middle value in a distribution, above and below which lie an equal number of values. This distribution is based on the databank.

(II) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, filled nursing facilities/intermediate care facilities, and intermediate care facilities as defined in Chapter 198, RSMo, participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

(JJ) Occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report. For a distinct part facility that completes a worksheet one (1) of cost report, version MSIR-1 (3-95), determine the occupancy rate from the total actual patient days from the certified portion of the facility divided by the total bed days from the certified portion for the same period, as determined from the desk audited and/or field audited cost report.

(KK) Patient care. This cost component includes the following lines from the cost report version MSIR-1 (3-95): lines 46-69.

(LL) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the allowable temporary leave-of-absence days per subsection (5)(D) and hospital leave days per subsection (5)(M). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(MM) Per diem. The daily rate calculated using this regulation's cost components and used in the determination of a facility's prospective and/or interim rate.

(NN) Provider or facility. An HIV nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing HIV nursing facility services to Title XIX-eligible recipients.

(OO) Prospective rate. The rate determined from the rate setting cost report.

(PP) Rate setting cost report. The desk audited and/or field audited cost report relating to a facility's rate setting period.

(QQ) Rate setting period. The period for

which a facility's prospective rate is determined. The rate setting period shall apply to the annual rebasing of rates as set forth in (3)(N) as well as to facilities who have an interim rate and whose initial prospective rate is being set. For interim rate facilities, the rate setting period is the second full twelve (12)-month cost report following the facility's initial date of Medicaid certification.

(RR) Reimbursement rate. A prospective or interim rate.

(SS) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and such benefits exceed those which are usual and customary in such dealings.

2. An entity has an ownership or controlling interest in another entity; and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility.

3. As used in this regulation, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity. Ownership or controlling interest is when an entity:

(I) Has an ownership interest totaling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest

owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership.

C. Relative means person related by blood, adoption, or marriage to the fourth degree of consanguinity.

(TT) Replacement beds. Newly constructed beds never certified for Medicaid or previously licensed by the Division of Aging or the Department of Health and put in service in place of existing Medicaid beds. The number of replacement beds being certified for Medicaid shall not exceed the number of beds being replaced.

(UU) Renovations/major improvements. Capital cost incurred for improving a facility excluding replacement beds and additional beds.

(VV) Restricted funds. Funds, cash, cash equivalents, or marketable securities, including grants, gifts, taxes, and income from endowments which must only be used for a specific purpose designated by the donor.

(WW) Total facility size. Facility size plus increases minus decreases of licensed HIV nursing facility beds plus calculated bed equivalents for renovations/major improvements.

(XX) Unrestricted funds. Funds, cash, cash equivalents, or marketable securities, including grants, gifts, taxes, and income from endowments, that are given to a provider without restriction by the donor as to their use.

(YY) Incorporation by Reference. This rule adopts and incorporates by reference the provisions of the—

1. Financial and Statistical Report for Nursing Facilities (version MSIR-1 (3-95)) and the cost report instructions (revised 3/95) published by the Missouri Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, August 1, 2008. This rule does not incorporate any subsequent amendments or additions;

2. MO HealthNet Nursing Home Manual, which is published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, at its website [www.dss.mo.gov/mhd](http://www.dss.mo.gov/mhd), August 1, 2008. This rule does not incorporate any subsequent amendments or additions.

(5) Covered Supplies, Items, and Services. All supplies, items, and services covered in the reimbursement rate must be provided to the resident as necessary. Supplies and services



which would otherwise be covered in a reimbursement rate but which are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Covered supplies, items, and services include, but are not limited to, the following:

(A) Services, items, and covered supplies required by federal or state law or regulation which must be provided by nursing facilities participating in the Title XIX Program;

(B) Semi-private room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc.;

(D) Temporary leave of absence days for Medicaid recipients, not to exceed twelve (12) days for the first six (6) calendar months and not to exceed twelve (12) days for the second six (6) calendar months. Temporary leave of absence days must be specifically provided for in the recipient's plan of care and prescribed by a physician. Periods of time during which a recipient is away from the facility visiting a friend or relative are considered temporary leaves of absence;

(E) Provision of personal hygiene and routine care services furnished routinely and uniformly to all residents;

(F) All laundry services, including personal laundry;

(G) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(H) All consultative services required by federal or state law or regulations;

(I) All therapy services required by federal or state law or regulations;

(J) All routine care items including, but not limited to, those items specified in Appendix A to this regulation;

(K) All nursing services and supplies including, but not limited to, those items specified in Appendix A to this regulation;

(L) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's reimbursement rate; and

(M) Hospital leave days as defined in 13 CSR 70-10.070.

(6) Noncovered Supplies, Items, and Services. All supplies, items, and services which are either not covered in a facility's reimbursement rate or are billable to another program in Medicaid, Medicare, or other third party payor. Noncovered supplies, items, and services include, but are not limited to, the

following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc. Unless a private room is necessary due to such a medical or social condition, a private room is a noncovered service and a Medicaid recipient or responsible party may therefore pay the difference between a facility's semi-private charge and its charge for a private room. Medicaid recipients may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate unless the recipient or responsible party specifically requests in writing a private room prior to placement in a private room and acknowledges that an additional amount not payable by Medicaid will be charged for a private room;

(B) Supplies, items, and services for which payment is made under other Medicaid Programs directly to a provider or providers other than providers of the HIV nursing facility services; and

(C) Supplies, items, and services provided nonroutinely to residents for personal comfort or convenience.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness of compensation shall be limited as prescribed in subsection (8)(Q).

2. Compensation shall mean the total benefit, within the limitations set forth in this regulation, received by the owner for the services rendered to the facility. This includes direct payments for managerial, administrative, professional, and other services, amounts paid for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this regulation. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the *Medicare Provider Reimbursement Manual*, Part 1, section 906.4.

(B) Covered services and supplies as defined in section (5) of this regulation.

(C) Capital Assets.

1. Capital Assets shall include historical costs that would be capitalized under GAAP. For example, historical costs would include, but are not limited to, architectural fees, related legal fees, interest and taxes during construction.

2. For purposes of this regulation, any asset or improvement having a useful life greater than one (1) year in accordance with American Hospital Association depreciable guidelines, shall be capitalized.

3. In addition to the American Hospital Association depreciable guidelines, mattresses shall be considered a capitalized asset and shall have a three (3)-year useful life.

(D) Depreciation—Vehicle.

1. An appropriate allowance for depreciation on vehicles which are a necessary part of the operation of a HIV nursing facility is an allowable cost. One (1) vehicle per sixty (60) licensed beds is allowable. For example, one vehicle is allowed for a facility with zero to sixty (0-60) licensed beds, two (2) vehicles are allowed for a facility with sixty-one to one hundred twenty (61-120) licensed beds, etc. Depreciation is treated as an administration cost and is reported on line 133 of the cost report, version MSIR-1 (3-95).

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the vehicle and prorated over the estimated useful life of the vehicle in accordance with American Hospital Association depreciable guidelines using the straight line method of depreciation from the date initially put into service.

3. The basis of vehicle cost at the time placed in service shall be the lower of:

A. The book value of the provider;

B. Fair market value at the time of acquisition; or

C. The recognized Internal Revenue Service (IRS) tax basis.

4. The basis of a donated vehicle will be allowed to the extent of recognition of income resulting from the donation of the vehicle. Should a dispute arise between a provider and the division as to the fair market value at the time of acquisition of a depreciable vehicle, an appraisal by a third party is required. The appraisal cost will be the sole responsibility of the HIV nursing facility.

5. Historical cost will include the cost incurred to prepare the vehicle for use by the HIV nursing facility.

6. When a vehicle is acquired by trading in an existing vehicle, the cost basis of the new vehicle shall be the sum of undepreciated cost basis of the traded vehicle plus the cash paid.

(E) Insurance.

1. Property insurance. Insurance cost on property of the HIV nursing facility used to provide HIV nursing facility services. Property insurance should be reported on line 107 of the cost report version MSIR-1 (3-95).

2. Other insurance. Liability, umbrella, vehicle, and other general insurance for the HIV nursing facility should be reported on line 136 of the cost report version MSIR-1 (3-95).



3. Workers' Compensation insurance should be reported on the applicable payroll lines on the cost report for the employee salary groupings.

(F) Interest and Finance Costs.

1. Interest will be reimbursed for necessary loans for capital asset debt at the Chase Manhattan prime rate on July 3, 1995, plus two percentage (2%) points. For replacement beds, additional beds, and new facilities placed in service after June 30, 1996, the prime rate will be updated annually on the first business day of each July based on the Chase Manhattan prime rate plus two percentage (2%) points.

2. Loans (including finance charges, prepaid costs, and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the operation, maintenance, or acquisition of the provider's facility.

3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to recipient care. Loans which result in excess funds or investments are not considered necessary.

4. A provider shall capitalize loan costs (for example lender's title and recording fees, appraisal fees, legal fees, escrow fees, and other closing costs), finance charges, prepaid interest, and discounts. The loan costs shall be amortized over the life of the loan on a straight line basis.

5. If loans for capital asset debt exceed the facility asset value, the interest associated with the portion of the loan or loans which exceeds the facility asset value shall not be allowable.

6. The following is an illustration of how allowable interest is calculated:

Outstanding Capital Asset Debt	\$2,500,000
Term of Debt	25 years
Interest Rate	(Chase Manhattan prime + 2%)
10 percent Facility Asset Value	\$2,000,000
Discount	\$125,000
Loan Costs	\$120,000

Allowable interest calculation—use the lesser of the facility asset value or the outstanding capital asset debt.

Other Allowable Borrowing Costs:

Discount—	
$\$2,000,000 / \$2,500,000 \times \$125,000 =$	\$100,000
Loan Cost—	
$\$2,000,000 / \$2,500,000 \times \$120,000 =$	\$96,000
Allowable Interest—	
$\$2,000,000 \times 10\% =$	\$200,000

Discount—	
$\$100,000 / 25 \text{ years} =$	\$ 4,000
Loan Cost—	
$\$96,000 / 25 \text{ years} =$	\$ 3,840
Allowable Interest and Other Borrowing Costs	\$207,840

7. Interest cost on vehicle debt for allowable vehicles per paragraph (7)(D)1. is treated as an administration cost and reported on line 134 of the cost report version MSIR-1 (3-95).

(G) Rental and Leases.

1. Capitalized leases, as defined by GAAP, will be reimbursed in accordance with subsections (7)(C) and (7)(E).

2. Lease cost related to allowable vehicles per paragraph (7)(D)1. shall be treated as an administrative cost and be reported on line 135 of the cost report version MSIR-1 (3-95).

3. Operating leases, as defined by GAAP, will be part of the fair rental value system.

(H) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility used to provide HIV nursing facility services.

(I) Value of Services of Employees.

1. Except as provided for in this regulation, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations shall not be an allowable cost, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost, provided that the services are not of a religious nature and are compensated. Costs of wardrobe and similar items shall not be allowable.

(J) Employee Benefits.

1. Retirement plans.

A. Contributions to IRS qualified retirement plans shall be an allowable cost.

B. Amounts funded to pension and qualified retirement plans, together with associated income, shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

2. Deferred compensation plans.

A. Contributions shall be allowable costs when, and to the extent that, these costs are actually paid by the provider. Provider

payments for unfunded deferred compensation plans will be considered an allowable cost only when paid to the participating employee.

B. Amounts paid by organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report.

3. Types of insurance which are considered an allowable cost:

A. Credit life insurance (term insurance), if required as part of a mortgage loan agreement. An example, would be insurance on loans granted under certain federal programs.

B. Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be an employee benefit and is an allowable cost. This cost should be reported on the applicable payroll lines on the cost report for the employees salary groupings.

C. Health, disability, dental, etc., insurances for employees/owners shall be allowable costs.

(K) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable, except for costs associated with Nurse Aide Training and Competency Evaluation Program.

2. Costs of education and training shall include travel costs but will not include leaves of absence or sabbaticals.

(L) Organizational Costs.

1. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations; necessary accounting fees; expenses of temporary directors and organizational meetings of directors and stockholders; and fees paid to states for incorporation.

2. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

3. Where a provider is organized within a five (5)-year period prior to its entry into the program and has properly capitalized organizational costs using a sixty (60)-month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost under the program and shall



be amortized over the remaining part of the sixty (60)-month period.

4. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(M) Advertising Costs. Advertising costs which are reasonable and appropriate are allowable. The costs must be a common and accepted occurrence for providing HIV nursing facility services.

(N) Cost of Supplies and Services Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the cost report a provider shall identify related party suppliers and the type, the quantity, and costs to the related party for goods and services obtained from each such supplier.

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this regulation. The total of central office/home office and/or management company costs, as reported on lines 121 and 122 of the cost report, version MSIR-1 (3-95), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over sixty (60) months and would be reported on line 51 of the cost report, version MSIR-1 (3-95), RN.

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, the fee assessed to nursing facilities in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Nonallowable Costs. Costs not reasonably related to HIV nursing facility services shall

not be included in a provider's costs. Nonallowable costs include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;

(C) Capital cost increases due solely to changes in ownership;

(D) Charitable contributions;

(E) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

(F) Costs such as legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(G) Directors' fees included on the cost report in excess of two hundred dollars (\$200) per month, per individual;

(H) Federal, state, or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the department and attorneys fees which are not related to the provision of HIV nursing facility services, such as litigation related to disputes between or among owners, operators, or administrators;

(N) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Noncovered supplies, services, and items as defined in section (6);

(P) Owner's compensation in excess of the applicable range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers as published in the updated *Medicare Provider Reimbursement Manual* Part 1, section 905.2 and based upon the total number of working hours.

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owner/administrators will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the

high range. All others will be calculated on the median range.

2. The salary identified above will be apportioned on the basis of hours worked in the facility(ies), home office, or management company as applicable to total hours in the facility(ies), home office, or management company;

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers, or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided nonroutinely to residents for personal comfort or convenience;

(U) Salaries, wages, or fees paid to non-working officers, employees or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

(W) Taxes or assessments for which exemptions are available;

(X) Value of services (imputed or actual) rendered by nonpaid workers or volunteers;

(Y) All costs associated with Nurse Aide Training and Competency Evaluation Program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;
2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;

5. Cash, trade, quantity, time, and other discounts;

6. Purchase rebates and refunds;

7. Recovery on insured loss;

8. Parking lot revenues;

9. Vending machine commissions or profits;

10. Sales from supplies to individuals other than HIV nursing facility recipients;

11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;

12. Barber and beauty shop revenue;

13. Private room differential;

14. Medicare Part B revenues.

A. Revenues received from Part B charges through Medicare intermediaries will be offset.

B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;

15. Personal services;

16. Activity income; and



17. Revenue recorded for donated services and commodities.

(B) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

(D) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(E) As applicable, restricted and unrestricted funds will be offset in each cost component, excluding capital, in an amount equal to the cost component's proportionate share of allowable expense.

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report. The cost report (version MSIR-1 (3-95)) and cost report instructions (revised 3/95) are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerston Court, Jefferson City, MO 65109, August 1, 2008. This rule does not incorporate any subsequent amendments or additions.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the division an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose. Any substitute or computer generated cost report must have prior approval by the division.

3. All cost reports shall be completed in accordance with the requirements of this regulation and the cost report instructions. Financial reporting shall adhere to GAAP, except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified cash basis of accounting may continue to report on that basis, provided appropriate treatment for capital expenditures is made under GAAP.

5. Cost reports shall be submitted by the first day of the fourth month following the

close of the fiscal period, unless an extension has been granted.

6. If requested in writing and post-marked prior to the first day of the fourth month following the close of the fiscal period, one (1) thirty (30)-day extension of the filing date may be granted.

7. If a cost report is more than ten (10) days past due, payment shall be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation agreement and, if terminated, retain all payments which have been withheld pursuant to this provision.

8. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted or available upon request includes, but is not limited to, the following:

A. Audit prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years if requested by the division, the department, or its agents;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department, or its agents;

G. Leases and/or rental agreements related to the activities of the provider if requested by the division, the department, or its agents;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

9. Cost reports must be fully, clearly, and accurately completed. All required attachments must be submitted before a cost

report is considered complete. If any additional information, documentation, or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the division's request, payments may be withheld from the facility until the information is submitted.

10. Under no circumstances will the division accept amended cost reports for rate determination or rate adjustment after the date of the division's notification of the final determination of the rate.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by a person authorized by one (1) of the following: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of such authorization shall be furnished upon request.

2. Cost reports must be notarized by a commissioned notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature) (Title) (Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this regulation, including reasonable requests by the division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be separately maintained with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained





by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided or at the central office/home office if located in the state of Missouri. Copies of documentation and records shall be submitted to the division or its authorized agent upon request.

4. Each facility shall retain all financial information, data, and records relating to the operation and reimbursement of the facility for a period of not less than seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the division or its authorized agent.

2. A provider shall have available at the field audit location one (1) or more knowledgeable persons authorized by the provider and capable of explaining the provider's accounting and control system and cost report preparation, including all attachments and allocations.

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized agent for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering at a minimum the first two (2) full twelve (12)-month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings, and Statement of Cash Flow. For example, a provider begins participation in the Medicaid Program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve (12)-month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve (12)-month cost report, shall be audited. The audits shall be done by an independent certified public accountant.

(E) Change in Provider Status.

1. If a provider notifies, in writing, the director of the Institutional Reimbursement

Unit of the division prior to the change of control, ownership, or termination of participation in the Medicaid Program, the division will withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the fourth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with this regulation, any payment that was withheld will be released to the selling provider.

2. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, thirty thousand dollars (\$30,000) of the next available full month Medicaid payment, after learning of the change of control or ownership, will be withheld from the provider identified in the current Medicaid participation agreement until a cost report is filed. If the Medicaid payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. Once the cost report, prepared in accordance with this regulation, is received the payment will be released to the provider identified in the current Medicaid participation agreement.

(F) Joint Use of Resources.

1. If a provider has business enterprises in addition to the HIV nursing facility, the revenues, expenses, statistical, and financial records of each separate enterprise shall be clearly identifiable.

2. When the facility is owned, controlled, or managed by an entity or entities that own, control, or manage one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year-to-year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this regulation, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

(11) Cost Components and Per-Diem Calculation. The division will use the HIV nursing facility rate setting cost report.

(A) Patient Care. Each HIV nursing facility's patient care per diem shall be the lower of—

1. Allowable cost per patient day for patient care as determined by the division from the rate setting cost report; or

2. The per diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank.

(B) Ancillary. Each HIV nursing facility's ancillary per diem will be the lower of—

1. Allowable cost per patient day for ancillary as determined by the division from the rate setting cost report; or

2. The per diem ceiling of one hundred twenty percent (120%) of the ancillary median determined by the division from the data bank.

(C) Administration. Each HIV nursing facility's administration per diem shall be the lower of—

1. Allowable cost per patient day for administration as determined by the division from the rate setting cost report and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or

2. The per diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank.

(D) Capital. Each HIV nursing facility's capital per diem shall be determined using the fair rental value system as follows:

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report.

(II) Determine the number of increased licensed beds after the rate setting cost report.

(III) Determine the bed equivalency for renovations/major improvements after November 30, 1995, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost must be at least the asset value per bed for the year of the renovation/major improvement. For example, a renovations/major improvements cost of two hundred thousand dollars (\$200,000) is equal to six (6) beds. (\$200,000/\$32,723 equals 6.11 beds rounded to 6 beds).

(IV) Determine the number of decreased licensed beds after the rate setting cost report.

(V) Sum of (I), (II), (III) less (IV) times the asset value is the Total Asset Value.

B. Determine the reduction for age by multiplying the age of the beds by one percent (1%) up to forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).





(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, a facility with original licensure in 1977 of sixty (60) beds and an additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1993, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
Total		130	1750

Weighted Average Age—1750/130 beds = 13.5 years rounded to 14 years. This results in a reduction for age of the beds of fourteen percent (14%).

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1988, the reduction is calculated as follows

Licensure Year	Age	Beds	Age × Beds
1978	16	60	960
1988	6	60	360
Total		120	1320

Weighted Average Age—1320/120 = 11 years. This results in a reduction for age of the beds of eleven percent (11%).

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of sixty (60) beds, additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1993 and a reduction of ten (10) beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1993	1	10	10
1985*	17	(10)	(170)
Total		120	1580

\*reduction of 1977 beds

Weighted Average Age—1580/120 beds = 13.2 years rounded to 13 years. This results in a reduction for age of the beds of thirteen percent (13%).

(IV) The age of the beds equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120)-bed facility licensed in 1978 undertakes two (2) renovations:

two hundred thousand dollars (\$200,000) in 1983 and one hundred thousand dollars (\$100,000) in 1993. The asset value per bed is thirty-two thousand seven hundred twenty-three dollars (\$32,723). The bed equivalency is six (6) beds for 1983 and three (3) beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction Year	Age	Beds	Age × Beds
1978	16	120	1920
1983	11	6	66
1993	1	3	3
Total		129	1989

Weighted Average Method—1989/129 = 15.42 years rounded to 15 years. This results in a reduction for age of beds of fifteen percent (15%).

C. The facility asset value is subparagraph (11)(D)1.A. less subparagraph (11)(D)1.B.

D. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty (40)-year life.

E. The following is an illustration of how subparagraphs (11)(D)1.A., (11)(D)1.B., and (11)(D)1.C., (11)(D)1.D. determines the rental value:

(I) Total Facility Size	174 beds
Weighted Average Age of the Beds	23 years
Capital Asset Debt	\$2,371,094
Asset Value	\$ 32,723

(II) The Total Asset Value is the product of the Total Facility Size times the Asset Value;

Total Facility Size	174
Asset Value	× \$32,723
Total Asset Value	\$5,693,802

(III) Facility Asset Value is Total Asset Value less the Reduction for Age of the Beds; and

Reduction for Age (23%)	\$1,309,574
Facility Asset Value	\$4,384,228

(IV) Rental Value is the Facility Asset Value multiplied by 2.5%.

Rental Value	× 2.5%
	\$ 109,606

2. Rate of return.

A. Reduce the Facility Asset Value by the Capital Asset Debt, but not less than zero (0), times the percentage of return. The percentage of return is the yield for the thirty (30)-year Treasury Bond as reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending June 30, 1995, plus two (2) percentage points. The rate is 6.58% for the week ending June 30, 1995, plus 2% for a total of 8.58%.

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's rate

setting cost report and will be added to the capital asset debt from the rate setting cost report. The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(E)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility Asset Value	\$4,331,573
Capital Asset Debt	\$2,371,094
	\$1,960,479
Percentage of Return	× 9.48%
Rate of Return	\$ 185,853

3. Computed interest and pass through expenses.

A. Add property insurance (line 107) and property taxes (lines 108 and 109). Also add interest subject to limits identified in subsection (7)(F). These lines are found in the cost report, version MSIR-1 (3-95).

B. The following is an illustration of how subparagraph (11)(D)3.A. is calculated:

Computed Interest	\$207,840
Insurance	\$ 7,594
Property Taxes	\$ 40,548
Pass Through Expenses	\$ 48,142

4. Capital Component Per Diem Calculation.

A. A per diem is calculated by dividing the sum of rental value, rate of return, and computed interest by the number of beds determined in subparagraph (11)(D)1.A. times three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's occupancy from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.A. is calculated:

Rental Value	\$108,289
Rate of Return	\$185,853
Computed Interest	\$207,840
Total	\$501,982

Divided by Annualized Patient Days	56,077
Capital Per Diem	\$ 8.95

B. A per diem is calculated by dividing the pass through expenses by the greater of the minimum utilization as determined in subsection (7)(O) or the facility's patient days from the rate setting cost report. The following is an illustration of how subparagraph (11)(D)4.B. is calculated:

Pass Through Expenses	\$48,142
Patient Days	55,146
Pass Through Per Diem	\$ .87

C. The capital component per diem is the sum of subparagraph (11)(D)4.A. and (11)(D)4.B.

Capital Per Diem	\$ 8.95
Pass-Through Per Diem	\$ .87
Total Capital Component Per Diem	\$ 9.82



(E) Working Capital Allowance. Each HIV nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of each facility's per diem for patient care, ancillary, and administration times the Chase Manhattan prime rate on July 3, 1995, plus two (2) percentage points. The following is an illustration of how subsection (11)(E) is calculated:

Patient Care	\$30.00
Ancillary	\$ 7.00
Administration	<u>\$20.00</u>
Total Per Diem	<u>\$57.00</u>
divided by 12 months	<u>12</u>
	\$ 4.75
Times 1.1 months	<u>1.1</u>
	\$ 5.23
Times Prime + 2%	
(Chase Manhattan plus 2%)	<u>11%</u>
Working Capital Allowance per day	\$ .58

(F) The following is an illustration of how subsections (11)(A), (11)(B), (11)(C), (11)(D), and (11)(E) determine the per diem rate:

	<u>Allowable</u>	<u>Cost Ceiling</u>	<u>Per Diem</u>
Patient Care	\$38.00	\$40.00	\$38.00
Ancillary	\$ 8.00	\$ 6.00	\$ 6.00
Administration	\$12.00	\$11.00	\$11.00
Capital (FRV)			\$ 9.82
Working Capital Allowance			<u>\$ .58</u>
Total Per Diem			\$65.40

(12) Reimbursement Rate Determination. An HIV nursing facility's reimbursement rate shall be determined by the division as described in sections (11), (12), (13), and (14), subject to limitations prescribed elsewhere in this regulation.

(A) A facility entering the Medicaid Program after November 30, 1995, shall receive an interim rate as defined in subsection (4)(FF) to be effective on the initial date of Medicaid certification. A prospective rate shall be determined in accordance with section (11) from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve (12)-month fiscal year following the facility's initial date of Medicaid certification. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve (12)-month fiscal year.

(B) A facility with a valid Medicaid participation agreement in effect after November 30, 1995, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which re-enters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjust-

ments which may have been granted with effective dates subsequent to the termination date but prior to re-entry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the re-entry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section and 13 CSR 70-10.016.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments as set forth in 13 CSR 70-10.016. Global per diem rate adjustments shall be added to the specified cost component ceiling.

(B) Special Per Diem Rate Adjustments. Special per diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Replacement beds. A facility with a prospective rate in effect on or after November 30, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Division of Aging. The facility shall provide documentation from the Division of Aging that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (fair rental value, FRV) prior to the replacement beds being placed in service and the capital component per diem FRV including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

2. Additional beds. A facility with a prospective rate in effect on or after November 30, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem FRV prior to the additional beds being placed in service and the capital component per diem FRV including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional

beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

3. Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate, and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

A. When the provider can show that it incurred higher costs due to circumstances beyond its control, the circumstances were not experienced by the nursing home industry in general and the costs have a substantial cost effect;

B. Extraordinary circumstances include:

(I) Natural disasters such as fires, earthquakes, and floods that are not covered by insurance and that occur in a federally declared disaster area; and

(II) Vandalism and/or civil disorder that are not covered by insurance; and

C. The rate increase shall be calculated as follows:

(I) The one (1) time costs (costs that will not be incurred in future fiscal years):

(a) To determine what portion of the incurred costs will be paid, the division will use the patient occupancy days from latest available quarterly occupancy survey from the Division of Aging for the time period preceding when the extraordinary circumstances occurred; and



(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived.

(II) For ongoing costs (costs that will be incurred in future fiscal years): Ongoing annual costs will be divided by the greater of: annualized (calculated for a twelve (12)-month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits will be added to the prospective rate.

(III) For capitalized costs, a capital component per diem FRV will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem FRV prior to the extraordinary circumstances and the capital component per diem FRV including the extraordinary circumstances.

#### 4. Quality Assurance Incentive.

A. Each HIV nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per diem adjustment of \$3.20. The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 46 through 69 of Schedule B in the Title XIX Cost Report). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

(C) Conditions for Prospective Rate Adjustments. The division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

1. Fraud, misrepresentation, errors. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's prospective rate may be both retroactively and prospectively reduced if the fraudulent, mis-

represented, or inaccurate information as originally reported resulted in establishment of a higher, prospective rate than the facility would have received in the absence of such information. No decision by the division to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information shall in any way affect the division's ability to impose any sanctions authorized by statute or regulation. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher prospective rate than the facility would have received in the absence of this information also does not affect the division's ability to impose any sanctions authorized by statute or regulation;

2. Decisions of the Administrative Hearing Commission, or settlement agreements approved by the Administrative Hearing Commission;

3. Court Order; and

4. Disallowance of federal financial participation.

#### (14) Exceptions.

(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.

#### (15) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this regulation, the division may also impose sanctions against a provider in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services, or any other sanction authorized by state or federal law or regulations.

(B) Overpayments due the Medicaid Program from a provider shall be recovered by the division in accordance with state regulation 13 CSR 70-3.030, Sanctions for False or Fraudulent Claims for Title XIX Services.

(16) Appeals. In accordance with sections 208.156 and 622.055, RSMo, providers may seek hearing before the Administrative Hearing Commission of final decisions of the director or the division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid recipients, the amount paid in accordance with these regulations and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this regulation are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the regulation at least to the extent these services are available to the general public.

(19) Transition. Cost reports used for rate determination shall be adjusted by the division in accordance with the applicable cost principles provided in this regulation.

#### (20) Rebasing of HIV Nursing Facility Rates.

(A) Effective July 1, 2004, HIV nursing facility rates shall be rebased on an annual basis. The rebased rates shall be phased in as set forth below in subsection (20)(B). Each HIV nursing facility shall have its prospective rate recalculated using the same principles and methodology as detailed throughout sections (1)-(19) of this regulation, unless otherwise noted in this section (20). The following items have been updated to reflect the rebase:

1. HIV nursing facility rates shall be rebased on an annual basis using the cost report year that is three (3) years prior to the effective date of the rate change. For example, for SFY 2005, the effective date of the rate change is for dates of service beginning July 1, 2004 and the cost report year used to recalculate rates shall be 2001; for SFY 2006, the effective date of the rate change is for dates of service beginning July 1, 2005 and the cost report year used to recalculate rates shall be 2002; etc.

A. A new databank shall be developed from the cost reports for each rebase year in accordance with paragraph (20)(A)1. and subsection (4)(P).

B. The costs in the databank shall be trended using the indices from the most recent publication of the Health-Care Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the second quarter indices for each year. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2005, the trends are from the First Quarter 2004 publication of the Health-Care Cost Review and include the following:

(I) 2002:2 = 3.2%

(II) 2003:2 = 3.4%

(III) 2004:2 = 2.3%

(IV) 2005:2 = 2.3%

(V) The total trend applied to the 2001 cost report data is 11.2%.



C. The medians and ceilings shall be recalculated each year, based upon the trended costs included in the new databank that is developed each year.

D. The costs, beds, days, renovations/major improvements, loans, etc. from each facility's cost report included in the databank shall be used to recalculate each facility's rate. The costs reflected in each facility's cost report shall be trended as detailed above in (20)(A)1.B.

2. The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be updated each year based upon the RS Means Building Construction Cost Data for the year coinciding with the effective date of the rates. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the "S.F., C.F., and % of Total Costs" table and adjusting it by the total weighted average index for Missouri cities from the "City Cost Indexes" table. For SFY 2005, the asset value shall be forty-one thousand seven hundred twenty-eight dollars (\$41,728).

3. The age of the beds shall be calculated from the year coinciding with the effective date of the rates.

4. The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be updated to reflect the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%).

5. The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be updated to reflect the interest (i.e., coupon) rate for the most recent issue of thirty (30)-year Treasury Bonds in effect on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the rate of return shall be the thirty (30)-year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%.

6. The administration cost component per diem calculation shall not be adjusted for minimum utilization.

7. The capital cost component per diem calculation shall be adjusted for minimum utilization using the Department of Health and Senior Services' (DHSS) Intermediate Care Facility/Skilled Nursing Facility

Certificate of Need Quarterly Survey (CON Quarterly Survey) for the most recent quarter available to the division relative to the effective date of the rates. The occupancy data from the CON Quarterly Survey shall be adjusted by the division using total licensed beds rather than available beds as is used by DHSS. For SFY 2005, the minimum utilization percent for the capital component is the adjusted industry average from the October–December 2003 CON Quarterly Survey and shall be seventy-three percent (73%).

8. Since rates are being recalculated each year, rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)1., (13)(B)2., and (13)(B)3. are no longer allowed.

(B) The rebased rates shall be phased in, as set forth below:

1. A preliminary rebased rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in paragraphs (20)(A)1.–8.

2. The total increase resulting from the rebase each year shall be calculated as follows:

A. Each facility's current rate as of June 30 of each year shall be compared to the preliminary rebased rate effective July 1 of the following SFY. For example, for SFY 2005, the facility's rate as of June 30, 2004 shall be compared to the preliminary rebased rate effective July 1, 2004; for SFY 2006, the facility's rate as of June 30, 2005 shall be compared to the preliminary rebased rate effective July 1, 2005; etc.

(I) The NFRA shall not be included in the current rate or the preliminary rebased rate for comparison purposes in determining the total increase.

(II) The current NFRA shall be added to the rate determined below in subparagraph (20)(B)2.B.

B. If the preliminary rebased rate is greater than the current rate, the difference between the two (2) shall represent the total increase that will be phased in by granting one-third (1/3) of the total increase each year. For SFY 2005, one-third (1/3) of the total increase shall be added to the facility's current rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in (13)(A)5. The current NFRA shall be added to that total and shall be the facility's prospective rate for SFY 2005.

C. If the preliminary rebased rate is less than the current rate, the facility shall continue to receive its current rate including the current NFRA for the SFY.

(C) Effective for dates of service beginning April 1, 2005, the rebased rates for SFY 2005 shall be calculated as follows:

1. The audited 2001 cost report data shall continue to be used to develop the databank and to determine each nursing facility's rebased rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility's final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective April 1, 2005. The following items have been revised for the April 1, 2005 rate calculation:

A. A new databank shall be developed using the audited 2001 cost report data set forth above in paragraph (20)(C)1. for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S).

B. The administration and capital cost components shall be adjusted for minimum utilization at eighty-five percent (85%) occupancy, rather than as set forth in paragraphs (20)(A)6.–7.

(21) Per Diem Rate Calculation Effective for Dates of Service Beginning July 1, 2005. Effective for dates of service beginning July 1, 2005, the rebase provisions set forth in section (20) shall not apply. Effective for dates of service beginning July 1, 2005, the per diem rates shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation, except that the data indicated in this section (21) shall be used.

(A) The audited 2001 cost report data shall be used to develop the databank and to determine each nursing facility's per diem rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility's final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective July 1, 2005.

1. A new databank shall be developed using the audited 2001 cost report data set forth above in subsection (21)(A) for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S).



2. The costs in the databank shall be trended using the second quarter indices from the First Quarter 2004 publication of the Health-Care Cost Review using the “CMS Nursing Home without Capital Market Basket” table. The costs shall be trended for the years following the cost report year, up to and including SFY 2005. The trends applied to the 2001 cost report data include the following:

- A. 2002:2 = 3.2%
- B. 2003:2 = 3.4%
- C. 2004:2 = 2.3%
- D. 2005:2 = 2.3%

E. The total trend applied to the 2001 cost report data is 11.2%.

3. The medians and ceilings shall be recalculated, based upon the trended costs included in the new databank.

4. The costs, beds, days, renovations/major improvements, loans, etc. from each facility’s cost report included in the databank shall be used to calculate each nursing facility’s rate. The costs reflected in each facility’s cost report shall be trended as detailed above in paragraph (21)(A)2.

(B) The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be based upon the 2004 publication of the RS Means Building Construction Cost Data. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the “S.F., C.F., and % of Total Costs” table and adjusting it by the total weighted average index for Missouri cities from the “City Cost Indexes” table. The asset value shall be forty-one thousand seven hundred twenty-seven dollars and fifty cents (\$41,727.50).

(C) The age of the beds shall be calculated from 2004.

(D) The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June 2004 plus two percent (2%). The interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%).

(E) The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be the interest (i.e., coupon) rate for the most recent issue of thirty (30)-year Treasury Bonds in effect on the first business day of June 2004 plus two percent (2%). The rate of return shall be the thirty (30)-year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%.

(F) The administration and capital cost components shall be adjusted for minimum

utilization at eighty-five percent (85%) occupancy.

(G) Rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)1., (13)(B)2., and (13)(B)3. are no longer allowed.

(H) The rates effective for dates of service beginning July 1, 2005 shall be determined as set forth below:

1. A preliminary rate for July 1, 2005 shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in subsections (21)(A)–(G).

2. The total increase resulting from the July 1, 2005 preliminary rate calculation shall be calculated as follows:

A. Each facility’s rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in paragraph (13)(A)5., shall be compared to the July 1, 2005 preliminary rate calculation.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the June 30, 2004 rate or the July 1, 2005 preliminary rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraphs (21)(H)2.B. and (21)(H)2.C.

B. If the July 1, 2005 preliminary rate is greater than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in paragraph (13)(A)5., the difference between the two (2) shall represent the total increase. Effective for dates of service beginning July 1, 2005, one-third (1/3) of the total increase shall be added to the facility’s rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in paragraph (13)(A)5. The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility’s prospective rate for dates of service beginning July 1, 2005.

C. If the July 1, 2005 preliminary rate is less than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in paragraph (13)(A)5., the facility’s prospective rate shall be the facility’s rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in paragraph (13)(A)5. plus the high volume

adjustment, if applicable, and the current NFRA.

**APPENDIX A**

**COVERED SUPPLIES AND SERVICES  
PERSONAL CARE**

- Baby powder
- Bedside tissues
- Bibs, all types
- Deodorants
- Disposable underpads of all types
- Gowns, hospital
- Hair care, basic including washing, cuts, sets, brushes, combs, nonlegend shampoo
- Lotion, soap, and oil
- Oral hygiene including denture care, cups, cleaner, mouthwashes, toothbrushes, and toothpaste
- Shaves, shaving cream, and blades
- Nail clipping and cleaning-routine

**EQUIPMENT**

- Arm slings
- Basins
- Bathing equipment
- Bed frame equipment including trapeze bars and bedrails
- Bed pans, all types
- Beds, manual, electric
- Canes, all types
- Crutches, all types
- Foot cradles, all types
- Glucometers
- Heat cradles
- Heating pads
- Hot pack machines
- Hypothermia blanket
- Mattresses, all types
- Patient lifts, all types
- Respiratory equipment: compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment, and related supplies, etc.
- Restraints
- Sand bags
- Specimen container, cup or bottle
- Urinals, male and female
- Walkers, all types
- Water pitchers
- Wheelchairs, standard, geriatric, and roll-about

**NURSING CARE/PATIENT CARE  
SUPPLIES**

- Catheter, indwelling and nonlegend supplies
- Decubitus* ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads, and/or turning frames, heel protectors, donuts and sheepskins
- Diabetic blood and urine testing supplies
- Douche bags
- Drainage sets, bags, tubes, etc.



Dressing trays and dressings of all types  
 Enema supplies  
 Gloves, nonsterile and sterile  
 Ice bags  
 Incontinency care including pads, diapers, and pants  
 Irrigation trays and nonlegend supplies  
 Medicine droppers  
 Medicine cups  
 Needles including, but not limited to, hypodermic, scalp, vein  
 Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel  
 Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A and D ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages of all types, cottonballs, and aerosol merthiolate, tongue depressors  
 Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags  
 Suture care including trays and removal kits  
 Syringes, all sizes and types including ascepto  
 Tape for laboratory tests  
 Urinary drainage tube and bottle

#### THERAPEUTIC AGENTS AND SUPPLIES

Supplies related to internal feedings  
 I.V. therapy supplies: arm boards, needles, tubing, and other related supplies  
 Oxygen (portable or stationary), oxygen delivery systems, concentrators, and supplies  
 Special diets

*AUTHORITY: sections 208.153 and 208.201, RSMo Supp. 2009.\* Original rule filed Aug. 1, 1995, effective March 30, 1996. Emergency amendment filed Oct. 15, 1996, effective Oct. 25, 1996, expired April 22, 1997. Emergency amendment filed Aug. 12, 1997, effective Sept. 1, 1997, expired Feb. 27, 1998. Amended: Filed Aug. 12, 1997, effective Feb. 28, 1998. Emergency amendment filed Sept. 19, 1997, effective Oct. 1, 1997, expired March 29, 1998. Amended: Filed Sept. 25, 1997, effective March 30, 1998. Emergency amendment filed Sept. 21, 1998, effective Oct. 1, 1998, expired March 29, 1999. Amended: Filed Sept. 21, 1998, effective May 30, 1999. Emergency amendment filed Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Amended: Filed Aug. 30, 1999, effective March 30, 2000. Emergency amendment filed July 18, 2000, effective July 28, 2000, expired Jan. 24, 2001. Amended: Filed June 30, 2000, effective Feb. 28, 2001. Emergency amendment filed Sept. 22, 2003, effective Oct. 1, 2003, terminated Oct. 29,*

*2003. Amended: Filed Sept. 22, 2003, effective May 30, 2004. Emergency amendment filed June 18, 2004, effective July 1, 2004, expired Dec. 15, 2004. Amended: Filed Aug. 16, 2004, effective Feb. 28, 2005. Emergency amendment filed March 21, 2005, effective April 1, 2005, expired Sept. 27, 2005. Emergency amendment filed June 20, 2005, expired Dec. 27, 2005. Amended: Filed March 29, 2005, effective Sept. 30, 2005. Emergency amendment filed June 15, 2006, effective July 1, 2006, expired Dec. 28, 2006. Amended: Filed May 15, 2006, effective Nov. 30, 2006. Emergency amendment filed Sept. 17, 2007, effective Oct. 1, 2007, expired March 28, 2008. Amended: Filed March 30, 2007, effective Nov. 30, 2007. Amended: Filed July 1, 2008, effective Jan. 30, 2009. Amended: Filed March 11, 2010, effective Sept. 30, 2010.*

*\*Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007 and 208.201, RSMo 1987, amended 2007.*

#### 13 CSR 70-10.100 Limitation on Allowable Capital Cost Overruns for New Institutional Health Services in Title XIX Reimbursement Rate Setting

*PURPOSE: This rule establishes a limitation on the allowance of capital cost overruns in the construction of new institutional health services for Title XIX reimbursement rate setting purposes.*

(1) For implementation purposes of this rule, the following definitions shall apply:

(A) Cost overrun is that part of project costs for new institutional health services in excess of ten percent (10%) of the initial project estimate;

(B) Initial project estimate—

1. Is the dollar amount for which the Missouri Health Facilities Review Committee issued a Certificate of Need (CON); or

2. For those facilities deemed to have received a CON, is the dollar amount specified on the binding construction or purchase contract which was executed prior to October 1, 1980;

(C) New institutional health services are those as specified in section 197.305(9), RSMo; and

(D) Project costs are those costs subject to review under CON and include the general construction costs, site work, land acquisition costs, architectural and engineering fees, contingency costs, interest during construction, financing costs and equipment acquisition costs.

(2) Project costs for new institutional health

services in excess of ten percent (10%) of the initial project estimates shall not be considered in establishing a Title XIX per-diem rate for the first thirty-six (36) months that a facility receives payment for services provided under section 208.152, RSMo for any facility that applies for approval or consent for a cost overrun on or after November 11, 1982. This limitation is effective whether or not approval is granted under section 197.315.7, RSMo. If approval or consent is given, a facility's cost overrun will be considered in establishing a Title XIX per-diem rate after the thirty-six (36)-month period in accordance with the provisions of the Title XIX reimbursement plan applicable to the provider type and subject to the limitations.

(3) If a facility applies for approval or consent for a cost overrun prior to November 11, 1982, and subsequently receives the requisite approval or consent, the dollar amount of the cost overrun will be considered in establishing a Title XIX per-diem rate in accordance with the provisions of the Title XIX reimbursement plan applicable to the provider type and subject to the limitations of the plan, notwithstanding the provisions of section 197.357, RSMo.

*AUTHORITY: sections 207.020, RSMo Supp. 1993, 208.159, RSMo 1986 and 208.153, RSMo Supp. 1991.\* This rule was previously filed as 13 CSR 40-81.082. Emergency rule filed Aug. 5, 1982, effective Aug. 15, 1982, expired Nov. 10, 1982. Original rule filed Aug. 5, 1982, effective Nov. 11, 1982.*

*\*Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986, 1993; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; and 208.159, RSMo 1979.*

#### 13 CSR 70-10.110 Nursing Facility Reimbursement Allowance

*PURPOSE: This regulation is necessary to outline the provisions allowed in House Bill 1362.*

*PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.*



(1) Nursing Facility Reimbursement Allowance (NFRA). NFRA shall be assessed as described in this section.

(A) Definitions.

1. Nursing facility. An institution or a distinct part of an institution which—

A. Is primarily engaged in providing to residents—

(I) Skilled nursing care and related services for residents who require medical or nursing care; or

(II) Rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or

(III) On a regular basis, health-care and services to individuals who, because of their mental or physical condition, require care and services (above the level of room and board) which can be made available to them only through institutional facilities and is not primarily for the care and treatment of mental diseases; and

B. Has in effect a transfer agreement with one (1) or more hospitals as required by federal law; and

C. Meets the requirements for a nursing facility described in section 1919(b)-(d) of the Social Security Act; or

D. Is licensed in accordance with Chapter 198, RSMo, as a skilled nursing facility.

2. Fiscal period. A facility's twelve- (12-) month fiscal reporting period covering the same twelve- (12-) month period as its federal tax year.

3. Department. Department of Social Services.

4. Director. Director of the Department of Social Services.

5. Division. MO HealthNet Division, Department of Social Services.

6. Department of Health and Senior Services (DHSS). The Missouri state agency responsible for licensing and inspecting all long-term care facilities operating in Missouri and certifying annually those facilities participating in the Medicare or Medicaid program.

7. Engaging in the business of providing nursing facility services. Accepting payment for nursing facility services rendered.

8. Quarterly survey. The survey filled out each quarter by a nursing facility providing data on its licensed and certified beds and the related resident occupancy days (ROD) that is submitted to the DHSS. The survey form, "Missouri Department of Health and Senior Services, Division of Senior Services and Regulation, ICF/SNF Certificate of Need Quarterly Survey" (form MO 886-9001 (6-95)), incorporated by reference in this rule, is published by the Department of Health and

Senior Services, Division of Senior Services and Regulation, PO Box 570, Jefferson City, MO 65102. This rule does not incorporate any subsequent amendments or additions.

9. Applicable quarterly survey. The quarterly survey used by the division from which the patient occupancy days are taken to determine the NFRA assessment for a given period as set forth in section (2).

10. Patient occupancy days. The number of days that residents occupied the licensed beds in a nursing facility as shown on the quarterly survey, line D. "Number of occupied RODs (days patients in beds or beds held)."

11. Annualized level of patient occupancy days. The annual level of patient occupancy days used to determine the annual NFRA assessment.

A. For existing nursing facilities whose NFRA assessment is set in accordance with paragraph (1)(B)1. of this regulation, the annualized level of patient occupancy days is calculated by taking the number of patient occupancy days shown on line D. of the quarterly survey multiplied by four (4).

B. For nursing facilities whose NFRA assessment is not set by the general rule set forth in paragraph (1)(B)1. (i.e., it is an exception set under subparagraph (1)(B)1.A., is a new facility set under paragraph (1)(B)2., qualifies for a NFRA Adjustment in accordance with section (3), etc.), the annualized level of patient occupancy days may be calculated differently and is set forth in those sections.

12. Licensed beds. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

13. Licensed bed days. The total number of patient days available for use during a given period for all licensed beds. For purposes of this regulation, licensed bed days are calculated for an annual period and is the number of licensed beds times three hundred sixty-five (365) days.

14. Change of ownership. A change in the ownership, control, operator, or leasehold interest.

(B) Each nursing facility, except any nursing facility operated by the Department of Mental Health, engaging in the business of providing nursing facility services in Missouri shall pay a Nursing Facility Reimbursement Allowance (NFRA).

1. The NFRA owed for existing nursing facilities shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days from the applicable quarterly survey. The NFRA shall be divided by and collected over the number of months for which each NFRA rate is effective. The NFRA

rates, effective dates, and applicable quarterly surveys are set forth in section (2).

A. Exceptions.

(I) If an existing nursing facility's applicable quarterly survey, as set forth in section (2), does not represent a full quarter's worth of days due to a termination, temporary closure, change of ownership, etc., annualized level of patient occupancy days used to determine the NFRA shall be the greater of:

(a) The annualized level of patient occupancy days from the quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed days (i.e., number of licensed beds times three hundred sixty-five (365) days times fifty percent (50%)).

(II) If an existing nursing facility did not have patient occupancy information included on the applicable quarterly survey due to a termination, temporary closure, change of ownership, etc., the annualized level of patient occupancy days used to determine the NFRA shall be the greater of:

(a) The annualized level of patient occupancy days from the quarterly survey immediately prior to the applicable quarterly survey, if it represents a full quarter's worth of days; or

(b) Fifty percent (50%) of licensed bed days.

(III) If a nursing facility has ICF licensed beds and SNF licensed beds and none of the beds are Medicaid certified, only the SNF beds are subject to NFRA. The annualized level of patient occupancy days used to determine the NFRA shall be determined by multiplying the occupancy percentage from the applicable quarterly survey by the licensed bed days for the SNF licensed beds (i.e., number of SNF licensed beds times three hundred sixty-five (365) days).

(IV) If two (2) existing nursing facilities merge, with one (1) nursing facility terminating and transferring its beds to the remaining facility, the NFRA for the two (2) previously independent nursing facilities shall be added together and assessed to the remaining facility.

2. The initial NFRA owed by a newly licensed nursing facility that just opened as a result of receiving a Certificate of Need (CON) for a new nursing facility shall be calculated by multiplying the NFRA rate by the annualized level of patient occupancy days based on fifty percent (50%) of licensed bed days. The NFRA shall be prorated for the number of months remaining in the NFRA period. If a nursing facility's licensure date is after the first day of a month, the NFRA will





be collected beginning with the first day of the month following the actual licensure date.

3. If a nursing facility ceases to provide nursing facility services, the nursing facility is not required to pay the NFRA during the months in which it does not have residents, even though it may retain a license due to temporary closure for renovations, replacement, etc. If a nursing facility provided nursing facility services for any portion of a month, it shall pay the NFRA for the entire month (i.e., the NFRA shall not be prorated for the month in which it ceases to provide nursing facility services). If the facility reopens, it shall resume paying the NFRA. It shall owe the same NFRA as it did prior to closing, if the NFRA has not changed per section (2) below. If the NFRA has changed, the facility shall be assessed in accordance with paragraph (1)(B)1. above.

(C) Each nursing facility shall submit to the department a statement that accurately reflects—

1. If the nursing facility is owned and operated by the state of Missouri; and

2. If the nursing facility accepts payment for services rendered.

(D) The department shall prepare a confirmation schedule of the information from each nursing facility's 1994 second quarterly survey from the Division of Aging and provide each nursing facility with this schedule.

1. This schedule shall include:

A. Provider name;

B. Provider number; and

C. Total patient occupancy days.

2. Each nursing facility required to pay the Nursing Facility Reimbursement Allowance shall review the information in the schedule referenced in paragraph (1)(D)1. of this regulation and provide the department with correct information. If the information supplied by the department is incorrect, the facility within thirty (30) calendar days of receiving the confirmation schedule must notify the division and explain the corrections. If the division does not receive corrected information within thirty (30) calendar days, it will be assumed to be correct, unless the nursing facility files a protest in accordance with subsection (1)(F) of this regulation.

(E) Payment of the NFRA.

1. Offset. Each nursing facility may request that their Nursing Facility Reimbursement Allowance be offset against any Missouri Medicaid payment due to that nursing facility. A statement authorizing the offset must be on file with the division before any offset may be made relative to the nursing facility reimbursement allowance by the nursing facility. Assessments shall be allocated

and deducted over the applicable service period. Any balance due after the offset shall be remitted by the nursing facility to the department. The remittance shall be made payable to the Director of the Department of Revenue and deposited in the state treasury to the credit of the Nursing Facility Reimbursement Allowance Fund. If the remittance is not received before the next Medicaid payment cycle, the division shall offset the balance due from that check.

2. Check. If no offset has been authorized by the nursing facility, the division will begin collecting the nursing facility reimbursement allowance on the first day of each month. The NFRA shall be remitted by the nursing facility to the department. The remittance shall be made payable to the director of the Department of Revenue and deposited in the state treasury to the credit of the Nursing Facility Reimbursement Allowance Fund.

3. Failure to pay the NFRA. If a nursing facility fails to pay its NFRA within thirty (30) days of notice, the NFRA shall be delinquent. For any delinquent NFRA, the department may proceed to enforce the state's lien of the property of the nursing facility, may cancel or refuse to issue, extend, or reinstate the Medicaid provider agreement or may seek denial, suspension, or revocation of license granted under Chapter 198, RSMo. The new owner, as a result of a change in ownership, shall have his/her NFRA paid by the same method the previous owner elected.

(F) Each nursing facility, upon receiving written notice of the final determination of its Nursing Facility Reimbursement Allowance may file a protest with the director of the department setting forth the grounds on which the protest is based, within thirty (30) days from the date of receipt of written notice from the department. The director of the department shall reconsider the determination and, if the nursing facility so requested, the director or the director's designee shall grant the nursing facility a hearing to be held within forty-five (45) days after the protest is filed, unless extended by agreement between the nursing facility and the director. The director shall issue a final decision within forty-five (45) days of the completion of the hearing. After a final decision by the director, a nursing facility's appeal of the director's final decision shall be to the Administrative Hearing Commission in accordance with sections 208.156, RSMo and 621.055, RSMo.

(2) NFRA Rates. The NFRA rates determined by the division, as set forth in subsection (1)(B) above, are as follows:

(A) The NFRA will be two dollars and seventy-six cents (\$2.76) per patient occupancy

day for the period January 1, 1995 through September 30, 1995, and collected over nine (9) months (February 1995 through October 1995). The applicable quarterly survey for this period shall be the Division of Aging's June 1994 quarterly survey;

(B) The NFRA will be three dollars and fifty-five cents (\$3.55) per patient occupancy day for the period October 1, 1995 through September 30, 1996, and collected over twelve (12) months (November 1995 through October 1996). The applicable quarterly survey for this period shall be the Division of Aging's June 1995 quarterly survey;

(C) The NFRA will be five dollars and thirty cents (\$5.30) per patient occupancy day for the period October 1, 1996 through September 30, 1997, and collected over twelve (12) months (November 1996 through October 1997). The applicable quarterly survey for this period shall be the Division of Aging's June 1996 quarterly survey;

(D) The NFRA will be five dollars and eighty-eight cents (\$5.88) per patient occupancy day for the period October 1, 1997 through September 30, 1998, and collected over twelve (12) months (November 1997 through October 1998). The applicable quarterly survey for this period shall be the Division of Aging's June 1997 quarterly survey;

(E) The NFRA will be five dollars and eighty-eight cents (\$5.88) per patient occupancy day for the period October 1, 1998 through September 30, 1999, and collected over twelve (12) months (November 1998 through October 1999). The applicable quarterly survey for this period shall be the Division of Aging's June 1998 quarterly survey;

(F) The NFRA will be seven dollars and four cents (\$7.04) per patient occupancy day, effective October 1, 1999. The applicable quarterly survey for this period shall be the Division of Aging's June 1999 quarterly survey;

(G) The NFRA will be seven dollars and fifty cents (\$7.50) per patient occupancy day, effective July 1, 2000. The applicable quarterly survey for this period shall be the Division of Aging's December 1999 quarterly survey;

(H) The NFRA will be seven dollars and thirty cents (\$7.30) per patient occupancy day, effective July 1, 2001. The applicable quarterly survey for this period shall be the Division of Aging's December 2000 quarterly survey;

(I) The NFRA will be eight dollars and forty-two cents (\$8.42) per patient occupancy day, effective July 1, 2003. The applicable quarterly survey for this period shall be the





Department of Health and Senior Services' December 2002 quarterly survey;

(J) Effective January 1, 2005, the applicable quarterly survey shall be the June 2004 quarterly survey. The NFRA will continue to be eight dollars and forty-two cents (\$8.42) per patient occupancy day;

(K) Effective July 1, 2005, the applicable quarterly survey shall be updated at the beginning of each state fiscal year using the previous December's quarterly survey;

(L) Effective July 1, 2009, the NFRA will be nine dollars and seven cents (\$9.07) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K);

(M) Effective January 1, 2010, the NFRA will be nine dollars and twenty-seven cents (\$9.27) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K);

(N) Effective October 1, 2011, the NFRA will be eleven dollars and seventy cents (\$11.70) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K);

(O) Effective July 1, 2012, the NFRA will be twelve dollars and eleven cents (\$12.11) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K); and

(P) Effective July 1, 2015, the NFRA will be thirteen dollars and forty cents (\$13.40) per patient occupancy day. The applicable quarterly survey shall be as defined in subsection (2)(K).

(3) NFRA Adjustment Request. A facility being assessed the NFRA may request that its current NFRA assessment be adjusted, as set forth below.

(A) Qualifying Criteria. In order for a facility to receive an adjustment to its current NFRA assessment, it must meet all of the following criteria:

1. The facility must decrease its licensed bed capacity by at least fifteen percent (15%).

2. The facility must draft a written statement documenting that the decrease in licensed bed capacity is intended to be permanent.

A. If the facility increases its licensed capacity back to the original capacity within one (1) year of the decrease, the NFRA adjustment shall be voided and the facility shall resume paying the original NFRA beginning with the first of the month in which the facility made the request to DHSS to increase licensed capacity.

3. The annualized level of patient occupancy days currently being assessed is not

possible to attain because it is greater than one hundred percent (100%) of its new licensed capacity. For example, assume a facility had one hundred thirty (130) licensed beds and was being assessed on an average of one hundred (100) beds:

A. If a facility decreased its license by twenty (20) beds, being left with a total of one hundred ten (110) licensed beds, the facility could still obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is less than the one hundred ten (110) licensed bed capacity). Therefore, it would not meet the criteria for a NFRA adjustment.

B. If a facility decreased its license by forty (40) beds, being left with a total of ninety (90) licensed beds, the facility could not obtain the occupancy at which it was assessed (i.e., one hundred (100) beds being assessed is greater than the ninety (90) licensed bed capacity). Therefore, it would meet the criteria for a NFRA adjustment.

4. The facility must submit a written request to the division that includes an explanation as to why it believes it qualifies for an adjustment to its NFRA and documentation supporting its request. The following documentation is required:

A. A copy of the facility's request submitted to the DHSS and/or the CON program that its licensed bed capacity be decreased.

B. A copy of the license issued as a result of the request for the decrease and all licenses issued from that point forward to the current license.

C. If the facility's request submitted to the DHSS and/or the CON program to decrease its licensed bed capacity did not include a statement that the facility intended for the decrease to be permanent, such a statement must be submitted with the NFRA Adjustment Request.

D. The division may obtain this documentation and any other documentation it deems relevant to satisfy itself that the facility's licensed bed capacity has been decreased and the facility intends for the decrease to be permanent from the facility, the DHSS, the CON program, or any other source it deems appropriate.

E. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request, the division shall consider the NFRA Adjustment Request withdrawn.

(B) Calculation of Adjustment. A nursing facility meeting the criteria for a NFRA Adjustment shall have its NFRA recalculated and it shall replace the current NFRA. The

revised, adjusted NFRA shall be calculated as follows:

1. The facility's new, decreased licensed bed capacity shall be multiplied by three hundred sixty-five (365) days to determine the annualized level of patient occupancy days.

2. The new annualized level of patient occupancy days shall be multiplied by the current NFRA rate set forth in section (2) to determine the revised annual assessment.

3. The revised annual assessment shall be divided by twelve (12) months to determine the revised monthly assessment that the facility will owe beginning with the effective date of the adjustment.

(C) Effective Date of NFRA Adjustment. The effective date of the NFRA Adjustment shall be the first day of the month following the date the request is received; it will not be retroactive back to the effective date of the original NFRA.

*AUTHORITY: sections 198.401, 198.403, 198.406, 198.409, 198.412, 198.416, 198.418, 198.424, 198.427, 198.431, 198.433, 198.436, and 208.159, RSMo 2000, sections 208.153 and 208.201, RSMo Supp. 2013, section 198.421, RSMo Supp. 2014, and section 198.439, RSMo Supp. 2015.\* Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. Emergency amendment filed Sept. 5, 1995, effective Oct. 1, 1995, expired March 28, 1996. Amended: Filed May 30, 1995, effective Dec. 30, 1995. Amended: Filed Sept. 5, 1995, effective March 30, 1996. Emergency amendment filed Sept. 20, 1996, effective Oct. 1, 1996, expired March 29, 1997. Emergency amendment filed Sept. 19, 1997, effective Oct. 1, 1997, expired March 29, 1998. Amended: Filed Sept. 25, 1997, effective March 30, 1998. Emergency amendment filed Sept. 21, 1998, effective Oct. 1, 1998, expired March 29, 1999. Amended: Filed Sept. 21, 1998, effective May 30, 1999. Emergency amendment filed Sept. 20, 1999, effective Oct. 1, 1999, expired March 29, 2000. Amended: Filed Aug. 30, 1999, effective March 30, 2000. Amended: Filed Feb. 29, 2000, effective Oct. 30, 2000. Emergency amendment filed Aug. 29, 2001, effective Sept. 8, 2001, expired March 6, 2002. Amended: Filed Aug. 29, 2001, effective March 30, 2002. Emergency amendment filed Sept. 22, 2003, effective Oct. 1, 2003, terminated Oct. 29, 2003. Amended: Filed Sept. 22, 2003, effective May 30, 2004. Emergency amendment filed Dec. 17, 2004, effective Jan. 1, 2005, expired June 29, 2005. Amended: Filed Dec. 17, 2004, effective July 30, 2005. Emergency amendment filed Nov. 9, 2009, effective Nov. 19, 2009, expired Dec. 31, 2009. Amended: Filed July 1, 2009, effective Jan.*



30, 2010. Emergency amendment filed Dec. 1, 2009, effective Jan. 1, 2010, expired June 29, 2010. Amended: Filed Dec. 1, 2009, effective June 30, 2010. Emergency amendment filed Sept. 20, 2011, effective Oct. 1, 2011, expired March 28, 2012. Amended: Filed July 1, 2011, effective Dec. 30, 2011. Emergency amendment filed June 20, 2012, effective July 1, 2012, expired Dec. 28, 2012. Amended: Filed July 2, 2012, effective Jan. 30, 2013. Emergency amendment filed June 19, 2015, effective July 1, 2015, expired Dec. 28, 2015. Amended: Filed July 1, 2015, effective Jan. 30, 2016.

\*Original authority: 198.401, RSMo 1994; 198.403, RSMo 1994; 198.406, RSMo 1994; 198.409, RSMo 1994; 198.412, RSMo 1994; 198.416, RSMo 1994; 198.418, RSMo 1994; 198.421, RSMo 1994, 2014; 198.424, RSMo 1994; 198.427, RSMo 1994; 198.431, RSMo 1994; 198.433, RSMo 1994; 198.436, RSMo 1994, amended 1995; 198.439, RSMo 1994, amended 1996, 1999, 2002, 2005, 2006, 2007, 2011, 2015; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; and 208.201, RSMo 1987, amended 2007.

### 13 CSR 70-10.120 Reimbursement for Nurse Assistant Training

**PURPOSE:** This rule establishes a methodology for payment of nurse assistant training as required by the Omnibus Budget Reconciliation Act 87.

(1) Authority. This rule established pursuant to the authorization granted to the Department of Social Services, Division of Medical Services (DMS) to promulgate rules.

(2) Purpose. This rule establishes a methodology for payment of nurse assistant training as required by Omnibus Budget Reconciliation Act (OBRA) 87.

(3) Definitions.

(A) Nurse assistant training agency. An agency which is approved by the Division of Aging under 13 CSR 15-13.010(7).

(B) Basic course. The basic course shall mean the seventy-five (75) hours of classroom training, the one hundred (100) hours of on-the-job supervised training and the final examination of the approved nurse assistant training course.

(C) Challenge the final examination. This shall mean taking the final examination of the basic course without taking the entire basic course.

(D) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments, and all worksheets supplied by the division for this purpose per 13 CSR 70-10.010. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in

accordance with the procedures prescribed by the division, and on forms provided by and/or approved by the division.

(E) Department of Health. The department responsible for the survey, certification and licensure as prescribed in Chapter 198, RSMo.

(F) Desk audit. The Division of Medical Services or its authorized agent's audit of a provider's cost report without a field audit.

(G) Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure as prescribed in Chapter 198, RSMo.

(H) Division. Unless otherwise specified, division refers to the Division of Medical Services, the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) Program.

(I) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(J) Field audit. An on-site audit of the nursing facility's records performed by the department or its authorized agent.

(K) Nursing facility (NF). Effective October 1, 1990, skilled nursing facilities, skilled nursing facilities/intermediate care facilities and intermediate care facilities as defined in Chapter 198, RSMo participating in the Medicaid Program will all be subject to the minimum federal requirements found in section 1919 of the Social Security Act.

(L) Occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the desk audited and/or field audited cost report.

(M) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. Patient day includes the allowable temporary leave-of-absence days per 13 CSR 70-10.015(5)(D) and hospital leave days per 13 CSR 70-10.070. The day of discharge is not a patient day for reimbursement purposes unless it is also the day of admission.

(N) Provider or facility. A nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility services to Title XIX-eligible recipients.

(4) General Principles.

(A) Provisions of this reimbursement plan shall apply only to nursing facilities with valid provider agreements certified by the Division of Aging or the Department of Health for participation in the Missouri Medical Assistance (Medicaid) Program.

(B) The reimbursement determined by this

regulation shall apply only to costs incurred for nurse assistant training and competency evaluations for nurse assistants beginning the training after February 26, 1993.

(C) Program Approval—The Division of Aging will approve or disapprove nurse assistant training programs in the state of Missouri. If the Division of Aging withdraws approval of a formerly approved nurse assistant training program, the facility may continue to teach (and bill DMS for) those nurse assistants who had already begun the training program. However, that facility may not begin training (or bill the division) for any additional nurse assistants until it again receives approval from the Division of Aging. Nursing facilities receiving a "level A" violation or extended or partially extended survey will be ineligible for reimbursement for a period of two (2) years after the date of exit interview by the Division of Aging.

(D) Training Agencies—Any nurse assistant training agency must be approved by the Division of Aging per 13 CSR 15-13.010(7). This training agency must provide seventy-five (75) classroom hours of instruction and one hundred (100) hours on-the-job training. The seventy-five (75) classroom hours of instruction may include lecture, discussion, video/film usage, demonstration, and return demonstration by an approved registered nurse (RN) instructor who remains with and is always available to students to answer questions and to conduct the class. The one hundred (100) hours on-the-job training shall be done by an approved RN or licensed practical nurse (LPN) who meets 13 CSR 15-13.010 clinical supervisor qualifications and who directly observes their skills when checking their competencies. The one hundred (100) hours on-the-job training shall be devoted to the student; and the clinical supervisor or instructor must not have other job duties at the same time, such as but not limited to, charge nurse duties, medication pass duties and/or treatment duties. The facility will not be reimbursed in the per diem rate for the salary/fringes of the RN and/or LPN for time spent teaching the nurse assistant training program.

(E) Medicaid Cost Reports—Costs for nurse assistant training and competency evaluations are to be reported in the unallowable column on the Medicaid cost report and are not to be covered in the per diem rate. These costs include: any charge for training by an outside training agency, the cost of the competency evaluation, teacher salaries and fringes, necessary textbooks, and other required course materials. However, costs for salaries of nurse assistants in training or replacement nurse assistants for those in training or testing are to be reported in the



allowable column on the Medicaid cost report and are to be covered in the per-diem rate.

(F) Billing—Long-term care facilities with valid provider agreements may bill the Division of Medical Services for costs incurred for nurse assistant training and competency evaluations for nurse assistants beginning the training after February 26, 1993. Facilities may only bill for nurse assistants trained by an approved training agency and tested by an approved state examiner. This state examiner must be approved per 13 CSR 15-13.010(9) and must have a signed agreement with the Division of Aging. Facilities may bill once a month on an approved nurse assistant training billing form.

(G) Medicaid—Utilization Reimbursement will be allocated based on the ratio of Medicaid days to total patient days as reported on the latest Medicaid cost report filed by the facility with a year ending in the most recent year that all nursing facility Medicaid cost reports have been desk audited. If the facility did not have a Medicaid cost report ending in the most recent year that all nursing facility Medicaid cost reports have been desk audited, then the average ratio of Medicaid days to total patient days for all cost reports with ending dates in the most recent year that all nursing facility Medicaid cost reports have been desk audited will be used in calculating reimbursement.

(H) Prohibition of Charges—No nurse assistant who is employed by, or who has an offer of employment from, a nursing facility on the date on which the assistant begins a training and testing program may be charged for any portion of the program.

(5) Reimbursement for Nurse Assistants Employed at the Time of Training. If a nurse assistant is employed at a nursing facility and then passes an approved nurse assistant training and competency evaluation program, the division will reimburse a facility if all the following criteria are met:

(A) The nurse assistant is on the Missouri Division of Aging nurse assistant register;

(B) The individual is employed by the billing nursing facility at the time of passing the competency evaluation (final exam);

(C) The following reimbursement amounts will be prorated based on Medicaid utilization:

1. Three hundred sixty-five dollars (\$365) for a nurse assistant completing the entire basic course (all lesson plans, seventy-five (75) hours classroom training, and one hundred (100) hours on-the-job training) and passing the final exam;

2. A percentage of the three hundred sixty-five dollars (\$365) for nurse assistants

who only complete a portion of the lesson plans and pass the final exam will be paid. The percentage will be based on how many lesson plans were completed. For example:

If no on-the-job training was provided and if only lesson plans 1, 2, 4, 5, 6, 8, 9, 10, 11, 12, 41, 42, and 43 were completed, the percentage of the \$365 allowable would be:

\$ 34.50 classroom training  
 $((18.36/\text{hr} \times 75 \text{ hrs})/10) = \$138$   
 $\$138 \times 18.75 \text{ hours}/75 \text{ hrs} = \$34.50$   
 \$ 0.00 on-the-job training (0 of 100 hours)  
 \$ 30.00 textbook and supplies  
 \$ 50.00 testing fee  
 \$ 25.00 certification fee  
 \$139.50 allowable to be prorated on Medicaid utilization

3. Seventy-five dollars (\$75) for nurse assistants who do not complete any lesson plans through a challenge and pass the final exam;

(D) The facility which employs the nurse assistant must submit the bill for reimbursement to the division on the approved billing form; and

(E) The facility must bill for nurse assistant training and/or competency exam within one (1) year after the nurse assistant passed the final exam. Nurse assistant training that was completed prior to one (1) year before the effective date of this regulation and began after February 26, 1993, will be allowed.

(6) Reimbursement for Nurse Assistants Not Yet Employed at the Time of Training. If a nurse assistant is not employed at a nursing facility and that individual pays for the nurse assistant training and competency evaluation program, the division will reimburse a facility if all the following criteria are met:

(A) The nurse assistant is on the Missouri Division of Aging nurse assistant register;

(B) The individual is employed by the billing nursing facility not later than twelve (12) months after passing the final exam;

(C) The individual incurred costs for the training and testing, and the billing nursing facility submits to the division documentary evidence of those costs. The division will not reimburse costs if the nurse assistant received funding for the training through a grant or other funding source that is not required to be repaid by the nurse assistant;

(D) The billing nursing facility must submit documentation that it has paid the nurse assistant for the cost it is submitting to the division;

(E) The facility which employs the nurse assistant must submit the bill for reimburse-

ment to the division on the approved billing form;

(F) The division will prorate costs based on Medicaid utilization as follows:

1. Three hundred sixty-five dollars (\$365) for a nurse assistant completing the entire basic course (all lesson plans, seventy-five (75) hours classroom training, and one hundred (100) hours on-the-job training) and passing the final exam;

2. A percentage of the three hundred sixty-five dollars (\$365) for nurse assistants who only complete a portion of the lesson plans and pass the final exam. The percentage will be based on how many lesson plans were completed. See paragraph (5)(C)2. of this regulation; and

3. Seventy-five dollars (\$75) for nurse assistants who do not complete any lesson plans through a challenge process and pass the final exam; and

(G) The Division of Medical Services will subtract one-twelfth (1/12) of allowable reimbursement for each month that the nurse assistant is not employed after passing the final exam.

*AUTHORITY: sections 208.152, 208.153, 208.159 and 208.201, RSMo 1994. \* Original rule filed May 30, 1995, effective Dec. 30, 1995. Amended: Filed Feb. 15, 1996, effective Sept. 30, 1996.*

*\*Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991; 208.159, RSMo 1979; and 208.201, RSMo 1981.*

**13 CSR 70-10.150 Enhancement Pools**  
 (Rescinded June 30, 2018)

*AUTHORITY: sections 208.153, 208.159 and 208.201, RSMo 2000. Emergency rule filed Nov. 3, 2000, effective Nov. 13, 2000, expired May 11, 2001. Original rule filed Nov. 13, 2000, effective May 30, 2001. Emergency amendment filed July 9, 2001, effective July 19, 2001, expired Feb. 28, 2002. Amended: Filed July 9, 2001, effective Dec. 30, 2001. Emergency amendment filed Oct. 29, 2002, effective Nov. 8, 2002, expired May 6, 2003. Amended: Filed Oct. 29, 2002, effective April 30, 2002. Rescinded: Filed Nov. 3, 2017, effective June 30, 2018.*

**Rule Action Notice:** 13 CSR 70-10.150(1)(B) Rule Suspension. The Missouri Constitution authorizes the governor to control the rate at which appropriations are expended or reduce expenditures below the appropriated amount when actual revenues are less than estimated. The State Fiscal Year (SFY) 2002 revenue projection is expected to be \$750 million less



than the original consensus revenue forecast, which was established in December, 2000. This original forecast was the basis upon which the SFY 2002 budget was established by the General Assembly and the governor. The current revenue projection is \$230 million less than the revised consensus revenue forecast, which was established in December, 2001. Attempts to access the Rainy Day Fund were not supported by a super majority in the House, even though accessing the fund was proposed by the governor and supported by the Senate. Subsequently, the Department of Social Services was notified by the governor that monies appropriated in SFY 2002 for nursing facility efficiency grants in the approximate amount of \$20 million would not be available for expenditure. These monies were contained in House Bill II, Section II.445. At this time, the Department of Social Services must suspend the rule authorizing the payment of these monies, effective immediately.

**Action Taken:** Rule 13 CSR 70-10.150(1)(B) is suspended. Authority: *Missouri Constitution Article IV, Section 27, and sections 536.022 and 208.201, RSMo 2000. Rule suspension filed May 22, 2002.*

**Attention:** Pursuant to the Temporary Restraining Order of Circuit Judge Thomas J. Brown, of the 19th Judicial Circuit, Division I, entered on the 21st day of June 2002, this "Notice of Rule Suspension" is hereby temporarily enjoined from taking effect, until further action by said Court. *Cole County Circuit Court, Case No. 02CV324451. (see July 1, 2002, Missouri Register (27 MoReg II26-II28).*

### 13 CSR 70-10.160 Public/Private Long-Term Care Services and Supports Partnership Supplemental Payment to Nursing Facilities

**PURPOSE:** This rule implements a supplemental payment program for qualifying private and public nursing facilities.

(1) Effective for dates of service on or after April 1, 2012, through June 30, 2013, supplemental payments will be made as set forth in subsections (1)(A)–(1)(D) in each following calendar quarter from the Long-Term Support Upper Payment Limit (UPL) Fund to qualifying private and public nursing facilities for services rendered during the quarter on or after April 1, 2012 through June 30, 2013. Maximum payments to all qualifying private and public nursing facilities shall not

exceed the upper payment limit defined in 42 CFR 447.272 in each state fiscal year.

(A) Qualifying Criteria. The nursing facilities named in Section (13)(E)7. of the Medicaid State Plan are eligible for the Partnership Supplemental Payment and shall be referred to as qualifying nursing facilities. In addition, to qualify for the supplemental payment, a private or public nursing facility must be enrolled in MO HealthNet at the time the supplemental payment is calculated and made.

1. A private nursing facility is defined as being owned and operated by a private entity.

2. A public nursing facility is defined as being owned or operated by a public entity.

(B) Reimbursement Methodology. Qualifying private and public nursing facilities are eligible to receive supplemental payments for nursing facility services. Supplemental payments will be made in each calendar quarter after April 1, 2012.

1. Calculating qualifying nursing facilities quarterly Partnership Supplemental Per Diems—The quarterly per diem amount for each qualifying nursing facility shall be calculated as follows:

A. Dividing the available annual funding listed in Section (13)(E)6. of the Medicaid State Plan by the number of quarters in the fiscal period to obtain the quarterly funding amount;

B. Allotment between qualifying publicly owned and qualifying privately owned nursing facilities will be calculated as follows:

(I) The allotment for qualifying publicly owned nursing facilities will be the funding in subparagraph (1)(B)1.A. of this rule multiplied by eighty percent (80%); and

(II) The allotment for qualifying privately owned nursing facilities will be the funding calculated in subparagraph (1)(B)1.A. of this rule multiplied by twenty percent (20%);

C. The public nursing facility per diem is calculated by dividing the amount calculated in part (1)(B)1.B.(I) of this rule by the number of Medicaid paid days from the previous full state fiscal year divided by the four (4) quarters in the year for all qualifying public nursing facilities enrolled in the Medicaid program at the time the supplemental payments are made; and

D. The private nursing facility per diem is calculated by dividing the amount calculated in part (1)(B)1.B.(II) of this rule by the number of Medicaid paid days from the previous full state fiscal year divided by the four (4) quarters in the year for all qualifying private nursing facilities enrolled in the Medicaid program at the time the supplement-

tal payments are made.

2. Calculating qualifying nursing facilities' quarterly Partnership Supplemental Payments—The quarterly payment amount for each qualifying nursing facility enrolled in the Medicaid program shall be calculated as follows:

A. Each Medicaid enrolled qualifying nursing facility's Medicaid paid days from the previous full state fiscal year divided by the four (4) quarters in the year shall be multiplied by the Partnership Supplemental Payment per diem calculated in subparagraph (1)(B)1.C. of this rule for qualifying public nursing facilities and subparagraph (1)(B)1.D. of this rule for qualifying private nursing facilities to obtain each qualifying nursing facility's quarterly amount.

3. The time period used in calculating paragraphs (1)(B)1. and 2. of this rule will be the most recent state fiscal year for which data is available for the full fiscal year.

(C) Payment Limitations.

1. Public Nursing Facilities—Annual payment distributions for all qualifying individual public nursing facilities enrolled in the Medicaid program shall be limited to the qualifying individual public nursing facility's annual amount of unreimbursed Medicaid costs.

2. Private Nursing Facilities—Annual payment distributions for all qualifying private nursing facilities enrolled in the Medicaid program shall be limited to the difference between the qualifying nursing facility's Medicare equivalent payments as determined in the Medicare upper payment limit calculation and Medicaid payments the qualifying nursing facility receives for covered services provided to Medicaid recipients.

3. Any amount over the payment limitation for a qualifying individual nursing facility will be distributed to qualifying nursing facilities enrolled in the Medicaid program that have not reached their payment limitations as follows:

A. If any qualifying public nursing facility reaches its limitation described in paragraph (1)(C)1. above—

(I) The amount exceeding the limitation will be divided by the Medicaid days for the qualifying public nursing facilities enrolled in the Medicaid program within the pool that have not exceeded their limitations to obtain an additional Partnership Supplemental Payment Per Diem;

(II) This additional per diem will be paid to each qualifying public nursing facility enrolled in the Medicaid program that has not exceeded its limitation by multiplying the facility's Medicaid days by the per diem calculated in part (1)(C)3.A.(I) of this rule;



(III) The calculation in parts (1)(C)3.A.(I) and (II) of this rule will be repeated until the entire amount allocated to qualifying public nursing facilities enrolled in the Medicaid program has been expended or all of the qualifying public facilities enrolled in the Medicaid program have reached their limits as specified in paragraph (1)(C)1. of this rule; and

(IV) If any funding amount from the public allocation remains, it will be used to make Partnership Supplemental Payments to qualifying private nursing facilities enrolled in the Medicaid program.

B. If any qualifying private nursing facility reaches its limitation described in paragraph (1)(C)2. above—

(I) The amount exceeding the limitation will be divided by the Medicaid days for the qualifying private nursing facilities enrolled in the Medicaid program within the pool that have not exceeded their limitations to obtain an additional Partnership Supplemental Payment Per Diem;

(II) This additional per diem will be paid to each qualifying private nursing facility enrolled in the Medicaid program that has not exceeded its limitation by multiplying the facility's Medicaid days by the per diem calculated in part (1)(C)3.B.(I) of this rule;

(III) The calculation in parts (1)(C)3.B.(I) and (II) of this rule will be repeated until the entire amount allocated to qualifying private nursing facilities has been expended or all of the qualifying private facilities have reached their limits as specified in paragraph (1)(C)2. of this rule; and

(IV) Any remaining funding from the private allocation will be used to make Partnership Supplemental Payments to public nursing facilities.

C. Any remaining quarterly funding from either pool that cannot be paid due to payment limitations will be used in the reconciliation process described in subsection (1)(D) of this rule.

4. The time period used in calculating subsection (1)(C) of this rule will be the most recent state fiscal year for which data is available for the full fiscal year.

(D) Partnership Supplemental Payment Reconciliation—Prior to making payments each quarter, the department will calculate a reconciliation factor by—

1. Determining an amended aggregate payment amount by adjusting the available funding amount by any residual amount from subparagraph (1)(C)3.C. of this rule;

2. Dividing the amount established in paragraph (1)(D)1. of this rule by the original available funding amount to establish the reconciliation factor; and

3. The reconciliation factor from paragraph (1)(D)2. of this rule will be applied to the payments identified in subsection (1)(B) of this rule that are made during that fiscal year unless the department is unable to make the adjustment during the fiscal year due to the timing of the payments. In that case, the payments for the subsequent fiscal year will be adjusted by the difference between the amounts from paragraph (1)(D)1. of this rule and the available annual funding amount listed in Section (13)(E)6. of the Medicaid State Plan.

(2) Effective for dates of service beginning July 1, 2013, Nursing Facility UPL Payments shall be made as set forth below in subsections (2)(A)–(2)(C). Maximum aggregate payments to all qualifying nursing facilities shall not exceed the upper payment limit defined in 42 CFR 447.272 in each state fiscal year.

(A) An annual UPL Payment shall be made at the end of each state fiscal year (SFY) to qualifying nursing facilities.

(B) Qualifying Criteria. Public nursing facilities that have executed an agreement with the department are eligible for a UPL Payment and shall be referred to as qualifying nursing facilities. In addition, to qualify for the UPL Payment, each nursing facility must be enrolled in the Medicaid program at the time the UPL payments are calculated and made.

(C) Reimbursement Methodology. The annual UPL Payment will be made to qualifying nursing facilities based on each facility's unreimbursed costs determined from the facility's second prior year Medicaid cost report, subject to the Medicare Upper Payment Limit.

*AUTHORITY: section 208.201, RSMo Supp. 2014.\* Original rule filed Feb. 15, 2012, effective Aug. 30, 2012. Amended: Filed July 1, 2013, effective Jan. 30, 2014. Amended: Filed Aug. 15, 2014, effective Feb. 28, 2015.*

*\*Original authority: 208.201, RSMo 1987, amended 2007.*