



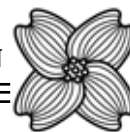
RULES OF

Department of Social Services

Division 70—MO HealthNet Division

Chapter 10—Nursing Home Program

Title	Page
13 CSR 70-10.005	Reasonable Cost-Related Reimbursement Plan for Long-Term Care 3
13 CSR 70-10.010	Prospective Reimbursement Plan for Long-Term Care12
13 CSR 70-10.015	Prospective Reimbursement Plan for Nursing Facility Services 37
13 CSR 70-10.016	Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates 62
13 CSR 70-10.017	Nursing Facility Invasive Ventilator Program 65
13 CSR 70-10.020	Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services 67
13 CSR 70-10.030	Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services. 90
13 CSR 70-10.040	Medicaid Eligibility and Preadmission Screening for Mentally Ill and Intellectually Disabled Individuals. 103
13 CSR 70-10.050	Pediatric Nursing Care Plan (Rescinded August 30, 2018) 105
13 CSR 70-10.060	Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services 105
13 CSR 70-10.070	Limitations on Allowable Nursing Facility Costs to Reserve a Bed for Absences Due to Hospital Admission 111
13 CSR 70-10.080	Prospective Reimbursement Plan for HIV Nursing Facility Services . . . 112
13 CSR 70-10.100	Limitation on Allowable Capital Cost Overruns for New Institutional Health Services in Title XIX Reimbursement Rate Setting127
13 CSR 70-10.110	Nursing Facility Reimbursement Allowance127
13 CSR 70-10.120	Reimbursement for Nurse Assistant Training. 131
13 CSR 70-10.150	Enhancement Pools (Rescinded June 30, 2018).133
13 CSR 70-10.160	Public Nursing Facility Upper Payment Limit Payments133



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 proprietors 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).

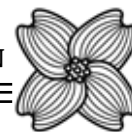
4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(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 band-aids, 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

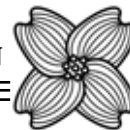
G. Self-employment Federal Insurance Contribution Act (FICA) taxes applicable to individual proprietors, partners, members of a joint venture, to the extent these taxes exceed the amount which would have been paid by the provider on the allowable compensation of these persons had the provider organization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

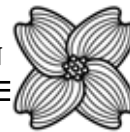
(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided the interest is applied to the replacement of the asset being depreciated. Interest income other than from funded depreciation in excess of interest expense will not be used to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

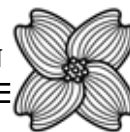
(G) A written notification indicating the SNF, ICF, ICF/MR and SNF/ICF combination per-diem rates respectively will be transmitted to the facility upon approval by the director, Department of Social Services or his/her designee.

(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
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
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
IV. 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

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.

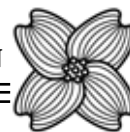
(E) The Medicaid per-diem rate shall be the lower of –

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.

AUTHORITY: section 207.020, RSMo Supp. 1993. * This rule was



(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;

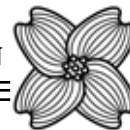
(L) All nursing care services and supplies, including disposables and including, but not limited to, those items specified in Appendix A to this rule;

(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 un depreciated 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.

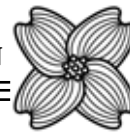
2. Deferred compensation plans.

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 nonproprietary 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.

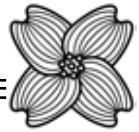
2. The salary identified in subparagraph (8)(Q)1.B. will be apportioned on the basis of hours worked in the facility(ies), home office or management company as applicable to total hours reported for all business interests. A forty (40)-hour minimum will be applied if total hours for all business interests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

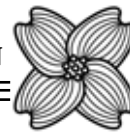
1. If a provider has business enterprises in addition to the LTC facility, the revenues, expenses, statistical and financial records of each separate enterprise shall be clearly identifiable.

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;

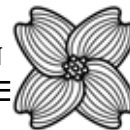
(b) One hundred six and two-tenths percent (106.2%) of the allowable cost per patient day as determined by the division from the cost report identified in subpart (12)(A)2.B.(I)(a) exceeds the LTCC in effect June 30, 1994, as identified in paragraph (3)(E)3.;

(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 adjustment factor (PPAF) times the LTCC on October 1, 1991, $(FPGF \times PPD \times PPAF \times LTCC)$. 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% $\times 9,750,000 \times 32.5\% \times \$56.98 = \$167,578$; 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 not 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.

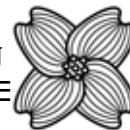
(III) The per-diem rate increase will be calculated as follows:

(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 copayments.

(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)

Stool Softeners, Nonlegend
Vitamins, Nonlegend

Other Services and Supplies as Otherwise Determined

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, Betadine, 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



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.



DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		QUARTERLY MEDICAID STATEMENT OF EXPENDITURES FOR THE MEDICAL ASSISTANCE PROGRAM SUMMARY SHEET			STATE		STATE AND LOCAL ADMINISTRATION	
					AGENCY		FEDERAL SHARE	
					QUARTER ENDED	STATE AND LOCAL ADMINISTRATION	TOTAL COMPUTABLE	FEDERAL SHARE
SECTION A QUARTERLY STATUS OF FUNDING		MEDICAL ASSISTANCE PAYMENTS						
		TOTAL COMPUTABLE (a)	FEDERAL SHARE (b)	TOTAL COMPUTABLE (c)	FEDERAL SHARE (d)			
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								
E.								
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 64.9o)								
11. NET EXPENDITURES REPORTED IN THIS PERIOD (SUM OF ITEMS 6, 7, AND 8 LESS 9 AND 10)								

FORM HCFA-64 (4-88)

FORM APPROVED
OMB NO. 0938-0067DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATIONMEDICAL ASSISTANCE EXPENDITURES BY TYPE OF SERVICE FOR THE
MEDICAL ASSISTANCE PROGRAM
EXPENDITURES IN THIS QUARTER

	TOTAL COMPUTABLE (a)	FMAP _____% (b)	I.H.S. FACILITY SERVICES 100% (c)	FEDERAL SHARE		TOTAL FEDERAL SHARE (f)
				FAMILY PLANNING SERVICES 90% (d)	_____% (e)	
MEDICAL ASSISTANCE PAYMENTS TYPE OF WAIVER _____ WAIVER NUMBER _____						
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 HCFA-64.9, LINE 6 (4-88)

PAGE 1 OF 2

FORM APPROVED
OMB NO. 0938-0067DEPARTMENT 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				STATE AGENCY	QUARTER ENDED	19
TOTAL COMPUTABLE		FMAP %	I.H.S. FACILITY SERVICES 100%	FEDERAL SHARE		TOTAL FEDERAL SHARE
(a)		(b)	(c)	90%	(d)	(f)
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 ¹						
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)).						

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

FORM HCFA-64.9, LINE 6 (4-88)

PAGE 2 OF 2



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0067

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

STATE

AGENCY

QUARTER ENDED

FISCAL YEAR

,19

CHECK ONE ☐ LINE 7. ☐ LINE 8. ☐ LINE 10.A. ☐ LINE 10.B.

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						
(1) PRESCRIBED DRUGS						
H. DENTAL SERVICES						
I. OTHER PRACTITIONERS' SERVICES						
J. CLINIC SERVICES						
K. LABORATORY AND RADIOLOGICAL SERVICES						





DEPARTMENT OF HEALTH AND HUMAN SERVICES HEALTH CARE FINANCING ADMINISTRATION		THIRD PARTY LIABILITY COLLECTIONS AND COST AVOIDANCE		STATE AGENCY	QUARTER ENDED	FEDERAL SHARE (b)
				(a)		, 19
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 (4-86)



OVERPAYMENT ACTIVITY	TOTAL COMPUTABLE (a)	FEDERAL SHARE				TOTAL FEDERAL SHARE (f)
		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 HCFA-64.90 (4-88)



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)	FEDERAL SHARE				TOTAL FEDERAL SHARE (f)
		90% (b)	75% (c)	50% (d)	% (e)	
		STATE AGENCY QUARTER ENDED				
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						
3. 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)).						

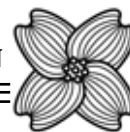
FORM HCFA-64.10, LINE 6 (4-88)



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	☐ LINE 7.	☐ LINE 8.	☐ LINE 10.A.			☐ LINE 10.B.	
TYPE OF WAIVER WAIVER NUMBER	TOTAL COMPUTABLE (a)	90% (b)	75% (c)	50% (d)	0% (e)	TOTAL FEDERAL SHARE (f)	DEFERRAL, DISALLOWANCE OR C.I.N. NO. (g)
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							
E. 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)).							

FORM HCFA-64 10p (4-88)

★ U.S. GOVERNMENT PRINTING OFFICE: 1989 - 241-194/93471



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. Emergency 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.*

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

PURPOSE: This rule establishes a reimbursement plan for nursing facility services required by the **Code of Federal Regulations**. The plan describes principles to be followed by Title XIX 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 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 MO HealthNet (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 participant's covered days of care, within benefit limitations as determined in subsections (5)(D) and (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 regulation. 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.

(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 participants 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.

(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 MO HealthNet 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 participant'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 in light of the provider's cost experience to determine any adjustments needed.

(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 non-certified bed in a nursing facility.

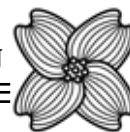
(R) All illustrations and examples provided throughout this regulation are for illustration purposes only and are not meant to be actual calculations.

(S) 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(s) (20)-(21), as applicable.

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.

(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 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 MO HealthNet Division 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) Audit. The examination or inspection of a provider's cost report, files, and any other supporting documentation by the MO HealthNet Division or its authorized contractor. The MO HealthNet Division or its authorized contractor may perform the following types of audits:

1. Level I Audit - Requires a limited review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The limited review may include, but is not limited to, items such as a comparative analysis of a provider's cost report data to industry data, a review of a provider's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level I audits may be provided off-site;

2. Level II Audit - Requires a desk review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The desk review may include, but is not limited to, review procedures in a Level I Audit, plus a more detailed analysis of a provider's cost report data to identify items that would require further review including requesting additional details of the reported information or documentation to support amounts reflected in the cost report. Level II audits may be provided off-site; and

3. Level III Audit - Requires an in depth audit, including, but not limited to, an on-site review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The Level III Audit will require an in depth analysis of a provider's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses. Level III audits will require some portions of the provider's records review be provided on-site.

(H) 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.

(I) 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.

(J) 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.

(K) 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.

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

(M) 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.

(N) 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.

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

(P) 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.).

(Q) 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.

(R) 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.

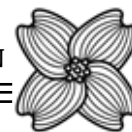
(S) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in paragraph (10) (A)7. of this regulation, and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with this regulation and the cost report instructions and shall be prepared on forms 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.

(T) 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 Health Care Finance Administration (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%.

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

(V) 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.

(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) 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.

(EE) 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.

(FF) 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.

(GG) 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.

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

(II) 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.

(JJ) 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.

(KK) 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.

(LL) 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 only has part of its total licensed beds certified for participation in the MO HealthNet program and that completes a worksheet one, version MSIR (7-93) or (3-95) of the cost report, determines 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.

(MM) 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.

(NN) 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.

(OO) 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.

(PP) 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 participants.

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

(RR) 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.

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

(TT) 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.

(UU) 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.

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

(WW) 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.

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

(YY) 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.

(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 that 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 that 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 participant due to a medical or social condition examples of which may be contagious infection, loud irrational speech;

(D) Temporary leave of absence days for Medicaid participants, 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 participant's plan of care and prescribed by a physician. Periods of time during which a participant 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 payer. 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 participant 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 non-covered service and a Medicaid participant or responsible party may therefore



pay the difference between a facility's semiprivate charge and its charge for a private room. Medicaid participants may not be placed in private rooms and charged any additional amount above the facility's Medicaid reimbursement rate 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 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 that are a necessary part of the operation of a nursing facility and are limited as follows: 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. Vehicles subject to the limit include cars, trucks, vans, sport utility vehicles (SUVs), and shuttle buses. Golf carts, utility terrain vehicles (UTVs), all terrain vehicles (ATVs), and other vehicles not aforementioned in this subsection shall not be included in the total vehicle count for the limit. 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 participant 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.

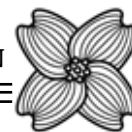
(L) Organizational Costs.

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 acting as 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 nonworking 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 participants;
 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 Howerton Court, Jefferson City, MO 65109, March 1, 2021. 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 or its authorized contractor an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division or its authorized contractor. The cost report shall be submitted on forms provided by the division or its authorized contractor for that purpose. Any substitute or computer generated cost report must have prior approval by the division or its authorized contractor.
 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.

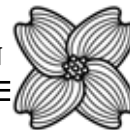
5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period. A provider may request, in writing, a reasonable extension of the cost report filing date for circumstances that are beyond the control of the provider and that are not a product or result of the negligence or malfeasance of the nursing facility. Such circumstances may include public health emergencies; unavoidable acts of nature such as flooding, tornado, earthquake, lightning, hurricane, natural wildfire, or other natural disaster; or, vandalism and/or civil disorder. The division may, at its discretion, grant the extension.

6. If a cost report is more than ten (10) days past due, payment may 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 or its authorized contractor. 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 authorized contractor;
- 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 authorized contractor;
- G. Leases and/or rental agreements related to the activities of the provider if requested by the division, the department, or its authorized contractor;
- 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 contractor 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 is not required for the following:

A. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX participants, relative to their fiscal year.

B. Change in provider status. The cost report filing requirement for the cost report relating to the terminating provider from a change of control, ownership, or termination of participation in the MO HealthNet program is not required, unless the terminating cost report is a full twelve- (12-) month cost report. If a rebase is done for a year in which there is no cost report, the cost report for the year prior to the change of control, ownership, or termination shall be used in the rebase calculation. A trend from the prior year cost report to the rebase year may be applied, if applicable.

11. Notification of change in provider status 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. The division may withhold funds due to a change in provider status as follows:

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. After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.; or

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. If the MO HealthNet payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. After six (6) months, 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.

(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 contractor 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 contractor 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 contractor 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 a Level III Audit (also known as a field audit) by the division or its authorized contractor.

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 contractor 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. The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first full twelve- (12-) month cost report.

(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).

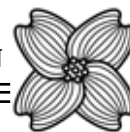
(V) The Total Facility Size is the sum of (I), (II), and (III) less (IV).

(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	<u>60</u>	<u>360</u>
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	<u>(10)</u>	<u>(170)</u>
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	<u>3</u>	<u>3</u>
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%)	<u>\$1,293,847</u>
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 lessor 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:

	Example A: Facility Asset Value < Debt	Example B: Facility Asset Value > Debt
<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.:

<i>Assumptions:</i>	
Loan costs	= \$120,000
Discount costs	= \$125,000
Total borrowing costs	= <u>\$245,000</u>

	Example A	Example B
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:

	Allowable Cost	Computed Patient Days*	Per Diem
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:

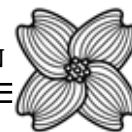
Total facility size	174
× 365 days	<u>× 365</u>
Subtotal	63,510

Greater of minimum utilization or facility occupancy

× 88.30% **	
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:



	Allowable Cost	Patient Days*	Per Diem
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:

	Allowable	Cost Ceiling	Per Diem
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 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.

(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 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 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.



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>.82</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>.70</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:

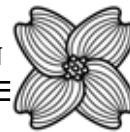
A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four (4) decimal places (.5985 or .8015 would not receive the adjustment), 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) Requirements for Placement of MO HealthNet Participants in Out-of-State Nursing Facilities and Reimbursement for Out-of-State Nursing Facilities.

1. In order to provide nursing facility services to MO HealthNet participants when there is no Missouri nursing facility with a suitable bed available that meets the medical needs of the participant, the division may authorize placement of a MO HealthNet participant in an out-of-state facility.

2. The division will only authorize placement of a MO HealthNet participant into an out-of-state facility if –

A. No Missouri nursing facility bed is available that meets the medical needs of the participant;

B. In-state alternatives for providing services have been exhausted; and

C. Prior approval for placement into an out-of-state nursing facility is requested from and approved by the division.

3. Once a Missouri nursing facility bed meeting the medical needs of the participant is available, the participant must return to Missouri. If the participant does not return to Missouri, the division shall withhold payments for nursing facility services, unless the participant's health would be endangered if required to travel to Missouri. Participant's physician would need to certify that the participant's health would be endangered from the travel to Missouri.

4. No fiscal year-end Missouri Medicaid cost report will be required from the out-of-state nursing facility nor will there be any requirement for Missouri-conducted periodic audits.

5. The Title XIX reimbursement rate for out-of-state providers shall be set as follows:

A. For out-of-state providers which provided services for Missouri Title XIX participants, the reimbursement rate shall be the lower of –

(I) The weighted average MO HealthNet rate for comparable services at the beginning of the state fiscal year in which the provider enters the MO HealthNet program; or

(II) The rate paid to the out-of-state nursing facility for comparable services by the state in which the provider is located. The out-of-state provider must notify the division of any reimbursement changes made by its state Medicaid agency. The provider must also include a copy of the rate letter issued by their state Medicaid agency detailing the rate and effective date. The effective date of the rate change is as follows:

(a) Rate increases – 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 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.

(B) The Title XIX reimbursement rate for hospital based providers that provide services of less than one thousand (1,000) patient days for Missouri Title XIX participants, relative



to their fiscal year, and that are exempt from filing a cost report as prescribed in section (10) shall be determined as follows:

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 the patient care, ancillary, and administration cost components, plus the 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; and

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 participants, 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.

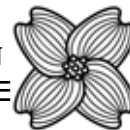
D. The costs, beds, days, renovations/major improvements, loans, etc. from each facility's cost report included in the databank shall be used to recalculate each facility's rate. The costs reflected in each facility's cost report shall be trended as detailed above in (20)(A)1.B.;

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.

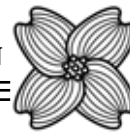
(D) The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June 2004 plus 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;

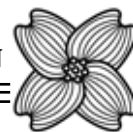
(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the *Health-Care Cost Review* available to the division using the "CMS Nursing Home without Capital Market Basket" table. The allowable costs 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.

(22) Prospective Rate Determination Beginning November 1, 2020. Prospective rates determined on or after November 1, 2020 shall be calculated as follows:

(A) 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. The nursing facility shall have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification, referred to as the rate setting cost report. The period to which the rate setting cost report relates is referred to as the rate setting period;

(B) 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; and

(C) The prospective rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed in subsections (21)(A)–(L), except for the following:

1. Paragraphs (21)(L)2. and (21)(L)3. shall not be applied in determining the prospective rate; and

2. The total rate determined from the rate setting cost report shall be adjusted by any global per diem adjustments granted after the beginning of the facility's rate setting period through the effective date of the prospective rate; and

3. The effective date for a facility's prospective rate is as follows:

A. The effective date for facilities with a rate setting cost report period that begins prior to November 1, 2020 shall be

November 1, 2020; and

B. The effective date for facilities with a rate setting cost report period that begins after November 1, 2020 shall be the beginning of the rate setting cost report period; and

4. The total rate that has been trended shall be limited to a cap, referred to as the total rate cap. The total trended rate shall be limited to the total rate cap that is in effect on the effective date of the prospective rate, as follows:

A. The total rate cap in effect on November 1, 2020 is one hundred ninety dollars (\$190); and

B. The total rate cap set forth above, one hundred ninety dollars (\$190), shall be adjusted by any global per diem adjustments granted after November 1, 2020; and

5. Once the prospective rate is finalized, a retroactive payment shall be made back to the effective date, if applicable; and

6. The prospective rate determined in (22)(C)1.-5. shall be adjusted by any global per diem adjustments set forth in 13 CSR 70-10.016 that are granted after the effective date of the prospective rate.

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 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, 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, 208.159, 208.201, and 660.017, RSMo 2016. 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. ** Amended: Filed Feb. 26, 2021, effective Aug. 30, 2021.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

***Pursuant to Executive Order 21-09, 13 CSR 70-10.015, paragraphs (10)(A)5. and 6. was suspended from April 9, 2020 through December 31, 2021.*

13 CSR 70-10.016 Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates

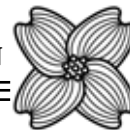
PURPOSE: This rule sets forth the global per diem adjustments to be applied to nursing facility reimbursement rates, established in 13 CSR 70-10.015, and HIV nursing facility reimbursement rates, established in 13 CSR 70-10.080. The global per diem adjustments were previously included in 13 CSR 70-10.015 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);

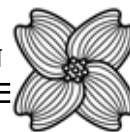
B. The per diem adjustment of five dollars and thirty-seven cents (\$5.37) shall be deducted from the facility's current rate as of July 31, 2017, and is effective for dates of service beginning August 1, 2017;

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.

22. FY-2019 trend adjustment –

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2018, shall be granted an increase to their per diem rate effective for dates of services beginning July 1, 2018, of seven dollars and seventy-six cents (\$7.76) to allow for a trend adjustment to ensure quality nursing facility services;



B. The rate to which the FY-2019 trend adjustment of seven dollars and seventy-six cents (\$7.76) shall be added is the facility's rate as of June 30, 2018, plus the fifty-four cents (\$0.54) per diem adjustment effective July 1, 2018, set forth in subparagraph (3)(A)21.C. and is effective for dates of service beginning July 1, 2018. This trend adjustment shall result in a rate no greater than eight dollars and thirty cents (\$8.30) higher than the rate in effect on January 1, 2018; and

C. This increase is contingent upon approval by the Centers for Medicare and Medicaid Services.

23. FY-2019 additional trend adjustment –

A. Facilities with either an interim rate or a prospective rate in effect on February 1, 2019, shall be granted an increase to their per diem rate effective for dates of service February 1, 2019 through June 30, 2019, of one dollar and twenty-nine cents (\$1.29) to allow for a trend adjustment to ensure quality nursing facility services;

B. The per diem adjustment of one dollar and twenty-nine cents (\$1.29) shall be added to the facility's rate as of January 31, 2019, and is effective for dates of service beginning February 1, 2019 through June 30, 2019;

C. Effective for dates of service beginning July 1, 2019, the per diem increase shall be reduced to fifty-four cents (\$0.54). A per diem adjustment of seventy-five cents (\$0.75) shall be deducted from the facility's rate as of June 30, 2019, which includes the one dollar and twenty-nine cents (\$1.29) increase, and is effective for dates of service beginning July 1, 2019.

D. These per diem adjustments are contingent upon approval by the Centers for Medicare and Medicaid Services.

24. FY-2020 trend adjustment –

A. Facilities with either an interim rate or a prospective rate in effect on August 1, 2019, shall be granted an increase to their per diem rate effective for dates of service August 1, 2019 through June 30, 2020, of one dollar and sixty-one cents (\$1.61) to allow for a trend adjustment to ensure quality nursing facility services;

B. The rate to which the FY-2020 trend adjustment of one dollar and sixty-one cents (\$1.61) shall be added is the facility's rate as of July 31, 2019 set forth in subparagraph (13)(A)23.C. The FY-2020 trend adjustment shall be effective for dates of service beginning August 1, 2019 through June 30, 2020.

C. Effective for dates of service beginning July 1, 2020, the per diem increase shall be reduced to one dollar and forty-nine cents (\$1.49). A per diem adjustment of twelve cents (\$0.12) shall be deducted from the facility's rate as of June 30, 2020, which includes the one dollar and sixty-one cents (\$1.61) increase, and is effective for dates of service beginning July 1, 2020.

D. These per diem adjustments are contingent upon approval by the Centers for Medicare and Medicaid Services

25. FY-2022 COVID-19 National Emergency adjustment –

A. Facilities with either an interim rate or a prospective rate in effect on July 1, 2021, shall be granted an increase to their per diem rate effective for dates of service July 1, 2021, through June 30, 2022, of ten dollars and eighteen cents (\$10.18) to allow for an adjustment for increases in costs associated with staffing, supplies, social distancing standards, and other factors due to the COVID-19 national emergency;

B. The rate to which the FY-2022 adjustment of ten dollars and eighteen cents (\$10.18) shall be added is the facility's rate as of June 30, 2021, set forth in subparagraph (13)(A)24.C. The FY-2022 adjustment shall be effective for dates of service beginning July 1, 2021, through June 30, 2022.

C. The FY-2022 adjustment will not be included in the

per diem rate for dates of service after June 30, 2022. A per diem adjustment of ten dollars and eighteen cents (\$10.18) shall be deducted from the facility's rate as of June 30, 2022, which includes the ten dollars and eighteen cents (\$10.18) increase, and is effective for dates of service beginning July 1, 2022.

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, 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. Amended: Filed Sept. 28, 2018, effective April 30, 2019. Emergency amendment filed Dec. 21, 2018, terminated May 31, 2019. Emergency amendment filed May 9, 2019, effective June 1, 2019, expired Dec. 30, 2019. Amended: Filed May 9, 2019, effective Dec. 30, 2019. Emergency amendment filed Jan. 16, 2020, effective Jan. 31, 2020, expired July 28, 2020. Amended: Filed Jan. 16, 2020, effective Aug. 30, 2020. Emergency amendment filed Sept. 13, 2021, effective Sept. 27, 2021, expired March 25, 2022. Amended: Filed Sept. 13, 2021, effective March 30, 2022.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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.

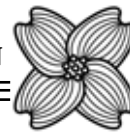
(B) Accessibility to Records. The provider must make accessible to MHD, MMAC, and/or DHSS all provider, participant, and other records necessary to determine that the needs of the participant are being met and to determine the appropriateness of invasive ventilator services.

(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 70-10.020 Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services

PURPOSE: This rule establishes a reimbursement plan for nursing facility and HIV nursing facility services required by the Code of Federal Regulations. The plan describes principles to be followed by Title XIX nursing facility and HIV nursing facility providers in preparing and submitting cost reports and sets forth the principles and methodology for determining the reimbursement for nursing facility and HIV nursing facility providers. This rule provides for a rebasing of nursing facility and HIV nursing facility per diem rates using a more current cost report year and incorporates acuity and value based purchasing adjustments in determining the per diem rate.

PUBLISHER'S NOTE: The secretary of state has determined that publication of the entire text of the material that 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 nursing facilities and human immunodeficiency virus (HIV) nursing facilities participating in the MO HealthNet Program, which is Missouri's Medicaid program. Hereinafter, the term nursing facility/ies shall refer to both nursing facilities and HIV nursing facilities unless specifically stated otherwise. 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 MO HealthNet (Medicaid) Program.

(B) The reimbursement rates determined by this regulation shall apply only to services provided on or after July 1, 2022.

(C) The effective date of this regulation shall be July 1, 2022.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible participant's covered days of care, within benefit limitations as determined in subsections (5)(D), 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 regulation. 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.

(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 participants 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 Missouri Medicaid Audit and Compliance division of the Department of Social Services.

(I) The division shall recover liabilities, sanctions, and penalties pertaining to the Medicaid Program associated with the provider number, regardless of when the services were rendered.

(J) Changes in ownership, management, control, operation, leasehold interest by any form for any facility previously certified for participation in the Medicaid Program at any time that results in increased 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 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 MO HealthNet Program on the same date as the Medicare termination.

(M) No restrictions nor limitations shall, unless precluded by federal or state law, be placed on a participant'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 in light of the provider's cost experience to determine any adjustments needed.

(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 end of the cost report period. 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 non-certified 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) 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;

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;

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);

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;

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;

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

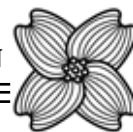
4. Nursing facility providers may not submit a MO HealthNet fee-for-service nursing facility claim for the same dates of service on the crossover claim for Medicare Part A and Medicare Advantage inpatient skilled nursing facility benefits. If it is determined that a MO HealthNet fee-for-service nursing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

(4) Definitions.

(A) Administration. This cost component includes costs reported in the cost report on lines 111-150.

(B) Age of beds. The age is determined by subtracting the initial licensing year from the rate base year used to determine the prospective rate.

(C) 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 MO HealthNet Division and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (CMS Publications 15-1



and 15-2), and Generally Accepted Accounting Principles (GAAP). Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* as the second source, and GAAP as the third source.

(D) Ancillary. This cost component includes costs reported in the cost report on lines 71-101.

(E) 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 (FRV) system as set forth in subsection (11)(D).

1. The 2019 asset value used in setting rates effective July 1, 2022, is sixty-four thousand seven hundred one dollars (\$64,701) and is calculated as follows:

A. The median cost per square foot for nursing facilities of one hundred fifty-six dollars (\$156) is multiplied by the average square feet per bed of four hundred thirty-five (435). This product is adjusted for Missouri cities. The sources of the data are as follows:

(I) Median cost per square foot – *2019 Building Construction Costs with RSMeans Data* publication, 50 17 | Project Costs table, Unit Costs Median of Total Project Costs for Nursing Home and Assisted Living;

(II) Average square feet per bed – 2019 cost report data bank; and

(III) Adjustment for Missouri cities – *2019 Building Construction Costs with RSMeans Data* publication, City Cost Indexes table, Weighted Average index for Missouri cities.

2. The 2019 asset value is adjusted annually on July 1 using the Historical Cost Indexes table from the *Building Construction Costs with RSMeans Data* publication for each year.

3. The adjusted asset values will be used to update the capital rate annually as set forth in paragraph (11)(H)4. and to set the prospective rate for new facilities. The asset value for the year relative to the rate base year (i.e., the end of the rate setting period) shall be used to determine the prospective rate for new facilities.

(F) Audit. The examination or inspection of a provider's cost report, files, and any other supporting documentation by the MO HealthNet Division or its authorized contractor. The MO HealthNet Division or its authorized contractor may perform the following types of audits:

1. Level I Audit - Requires a limited review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The limited review may include but is not limited to items such as a comparative analysis of a provider's cost report data to industry data, a review of a provider's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level I audits may be provided off-site;

2. Level II Audit - Requires a desk review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The desk review may include but is not limited to review procedures in a Level I Audit, plus a more detailed analysis of a provider's cost report data to identify items that would require further review including requesting additional details of the reported information or documentation to support amounts reflected in the cost report, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level II audits may be provided off-site; and

3. Level III Audit – Requires an in depth audit, including but

not limited to an on-site review of provider cost reports, files, and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The Level III Audit will require an in-depth analysis of a provider's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level III audits will require some portions of the provider's records review be provided on-site.

(G) Average private pay rate. The usual and customary charge for private pay patients determined by dividing total private patient days of care into private pay revenue, net of contractual allowances, for the same service that is included in the Medicaid reimbursement rate. Private pay revenue 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 not subtracted from private pay revenue in the computation of the average private pay rate.

(H) Bad debt. The difference between the amount expected to be received (i.e., revenues less contractual allowance) 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) Bed days. The total number of days that are available to care for patients based on a facility's total licensed beds, regardless of whether the bed is occupied or not. 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 of the cost report, bed days are calculated by multiplying the number of beds certified during the cost report period times the days in the cost report period.

(J) 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 in the cost report on lines 102-110.

(K) Capital asset. A facility's building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in the Medicare Provider Reimbursement Manual. Motor vehicles are excluded from this definition.

(L) Capital asset debt. The debt related to the capital assets as determined from the cost report.

(M) Capital expenditures. Capital costs incurred for improving a facility.

(N) Case Mix Index (CMI). Weight or numeric score assigned to a resident classification system (e.g., Resource Utilization Group (RUG), Patient-Driven Payment Model (PDP), etc.) grouping to reflect the relative resources predicted to care for a resident. The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident. Resident classifications are determined from information derived from the Minimum Data Set (MDS) evaluations for a given period.

1. Resident classification systems used to determine CMI.

A. RUG IV. Effective for dates of service from July 1, 2022, through June 30, 2024, the Resource Utilization Group (RUG) IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is used to



determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services (CMS) at its website, <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation>, June 29, 2022. Applicable files are RUG-IV DLL Package V1.04.1 Final (.zip) and RUG III Files & RUG IV Files (.zip). This rule does not incorporate any subsequent amendments or additions.

B. Patient Driven Payment Model (PDPM). Effective for dates of service beginning July 1, 2024, the PDPM nursing component case mix groups (CMG) and case mix index table effective October 1, 2023, as listed in the final Skilled Nursing Facility Prospective Payment System (SNF PPS) payment rule for FY 2024, as published by the Office of the Federal Register at 7 G Street NW, Suite A-734, Washington, DC 20401, August 7, 2023, is used to determine the CMIs used in this regulation and is incorporated by reference and made a part of this rule. This rule does not incorporate any subsequent amendments or additions.

2. Individual CMIs are calculated as follows:

A. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this rule;

B. An index maximizing methodology is used to calculate the individual CMI for RUG classifications. The index maximizing classification system will select the RUG with the highest CMI for individuals that qualify for multiple RUGs; and

C. A hierarchical methodology is used to determine the individual CMI for the PDPM nursing component classifications.

(I) The hierarchical classification system will work through the PDPM nursing classifications in order and select the first group for which the patient qualifies.

(II) The nursing classification hierarchical order includes –

- (a) Extensive services;
- (b) Special care high;
- (c) Special care low;
- (d) Clinically complex;
- (e) Behavioral symptoms and cognitive performance; and
- (f) Reduced physical function.

(III) The first of the twenty-five (25) individual PDPM nursing groups for which the patient qualifies is the assigned PDPM nursing classification.

3. Facility CMIs are calculated as follows:

A. Facility CMI calculations will be based on quarterly point-in-time data snapshots. These snapshot dates are January 1, April 1, July 1, and October 1;

B. The midnight census will determine the residents that are included in the facility's CMI;

C. The Assessment Reference Date (ARD) will be used to determine the assessment included in each quarterly CMI calculation;

D. A look-back period of one hundred eighty (180) days will be used to determine the residents included in calculating the facility CMI. The look-back period cutoff date is the day prior to the snapshot date (i.e., for the January 1 CMI calculation, the ARD would need to be December 31 or earlier);

E. The most current MDS assessment for an individual in the look-back period of one hundred eighty (180) days will be used;

F. Only assessments that are included in the MDS data sent to the state through the CMS system will be available for case mix calculations;

G. An average acuity level will be determined for each facility for each snapshot date by using a simple average of the CMI values for all residents included in the data for the snapshot date.

(I) Medicaid CMI. The average acuity level for Medicaid patients in a facility.

(a) Medicaid pending residents will be included in the facility's Medicaid CMI calculation.

(b) Medicaid hospice residents will be included in the facility's Medicaid CMI calculation.

(c) Medicaid managed care residents will be included in the facility's Medicaid CMI calculation.

(II) Total CMI. The average acuity level for all patients in a facility; and

H. When facility-specific CMI data is not available, the statewide average CMI will be used.

4. Resident listings.

A. Nursing facilities will be provided a draft resident listing to review for accuracy and will be given a minimum of two (2) weeks to correct resident listings that are not accurate.

(I) The draft resident listing will include resident specific information including but not limited to –

- (a) The resident's name and identification number;
- (b) The payment source;
- (c) The ARD;
- (d) The PDPM nursing code and corresponding CMI;
- (e) Whether the resident has a mental illness diagnosis that qualifies for the mental illness diagnosis add-on which is used to determine the facility's Medicaid CMI; and
- (f) Whether the facility qualifies for the mental illness diagnosis add-on.

(II) Nursing facilities will be notified when the draft resident listings are available to review and will include the due date for when all corrections must be done.

B. Facilities may submit corrections to the draft resident listings as follows:

(I) Payer source. Corrections to the payer source for a resident should be submitted to the division or its authorized contractor; and

(II) Other corrections. Any corrections to the data other than corrections to the payer source must be submitted through the CMS Internet Quality Improvement and Evaluations System (iQIES). Chapter 5 of the Long-term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual discusses submission and correction of MDS assessments. The RAI manual is incorporated by reference in this rule as published by the Centers for Medicare & Medicaid Services, 7500 Security Blvd., Baltimore, MD 21244, October 1, 2024. This rule does not incorporate any subsequent amendments or additions.

C. A final resident listing will be prepared based on the draft resident listing plus any corrections submitted by the facility by the due date.

D. No corrections will be accepted after the due date unless the division or its authorized contractor has given prior approval.

E. The final resident listing will be used to determine the CMI and mental illness diagnosis add-on included in a facility's per diem rate and will be provided when the final per diem rate is determined.

F. If any of a facility's corrections that were submitted on a timely basis were not captured in the final resident listing, the facility may submit a request to the division or its authorized contractor to review. The request must include documentation supporting their claim.

(O) 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.

(P) Certified bed. Any licensed nursing facility or hospital based bed that is approved by the Department of Social Services to participate in the Medicaid Program.

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

(R) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, (i.e., charity care provided by a religious organization for members, etc.).

(S) CMS Market Basket Index. An index that measures the price movements of goods, services, and labor purchased by nursing homes. The index is published quarterly in the *IHS Markit/Healthcare Cost Review*. The “Total - %MOVAVG” index from “Table 6.7 CMS Nursing Home without Capital Market Basket” shall be used for the trending calculations in this regulation. The same or comparable index and table shall continue to be used, regardless of any changes in the name or title of the publication, publisher, or table.

(T) 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.

(U) Cost components. The groupings of allowable costs used to calculate a facility’s per diem rate. They are patient care, ancillary, capital, and administration.

(V) Cost report. The Financial and Statistical Report for Nursing Facilities, cost report instructions, all worksheets supplied by the division for this purpose, and required attachments as specified in paragraph (10)(A)7. of this regulation. The cost report shall detail the cost of rendering both covered and non-covered services for the fiscal reporting period in accordance with this regulation and the cost report instructions and shall be prepared on forms provided by and/or as approved by the division.

1. Cost Report version MSIR-1 (3-95) and cost report instructions (revised 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).

2. 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 Howerton Court, Jefferson City, MO 65109, June 30, 2022. This rule does not incorporate any subsequent amendments or additions.

(W) Data bank. The data from the rate base year cost reports used to determine the medians, ceilings, and per diem rates for nursing facilities.

1. A separate data bank shall be created for nursing facilities and HIV nursing facilities, as follows:

A. The data bank for nursing facilities shall include all nursing facilities except hospital based facilities and HIV facilities; and

B. The data bank for HIV nursing facilities shall only include HIV nursing facilities.

2. 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. Beginning with the SFY 2025 rebase, cost reports must cover more than three (3) full months to be used for rebasing. Cost reports covering three (3) months or less will not be used. If a facility does not have a cost report for the rebase year, the cost report for the year prior to the rebase year shall be used.

3. Nursing facilities that terminated from the MO HealthNet program during the rate base year shall not be included in the data bank.

4. Nursing facilities operating under an interim rate that have at least a second full year cost report after entering the Medicaid program that coincides with the rate base year may be included in the data bank. Interim rate facilities without such a cost report for the rate base year shall not be included in the data bank. Beginning with the SFY 2025 rebase, nursing facilities operating under an interim rate will not be included in the data bank.

5. The initial rate base year used for rebasing shall be 2019 and the data bank shall include cost reports with an ending date in calendar year 2019. The 2019 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2022, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2019 year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

- (I) Aides and orderlies (Line 53 of CR (3-95));
- (II) Dietary salaries (Line 60 of CR (3-95));
- (III) Laundry salaries (Line 85 of CR (3-95));
- (IV) Housekeeping salaries (Line 91 of CR (3-95)); and
- (V) Beauty and barber salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in subparagraph (4)(W)5.A., shall be trended through June 30, 2022, by the difference in the CMS Market Basket Index (i.e., the “Total - %MOVAVG” index for 2022:2 from the fourth-quarter 2021 publication) and the midpoint of the facility’s rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a simple average of the four (4) quarterly total CMIs covering the facility’s cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

6. SFY 2025 rebase. Effective for dates of service beginning July 1, 2024, nursing facility rates shall be rebased using a data bank with cost report ending dates in calendar year 2022, except in instances where 2022 data is not available as explained in paragraph (4)(W)2. of this rule. The 2022 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2024, through such time rates are rebased again or calculated on some other cost report as set forth in regulation. The 2022 base year data shall be adjusted for the following and shall be used to determine the medians, ceilings,



and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

- (I) Aides and orderlies (Line 53 of CR (3-95));
- (II) Dietary salaries (Line 60 of CR (3-95));
- (III) Laundry salaries (Line 85 of CR (3-95));
- (IV) Housekeeping salaries (Line 91 of CR (3-95)); and
- (V) Beauty and barber salaries (Line 94 of CR (3-95));

B. The total allowable costs, including the salary adjustments detailed above in subparagraph (4)(W)6.A. of this rule, shall be trended through June 30, 2024, by the difference in the CMS Market Basket Index (i.e., the “Total – %MOVAVG” index for 2024:2 from the first-quarter 2024 publication) and the midpoint of the facility’s rate setting cost report year; and

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the state-wide average total CMI by multiplying the total patient care costs by the quotient of the state-wide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a resident-weighted average of the four (4) quarterly total CMIs covering the facility’s cost report period.

(II) The state-wide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

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

(Y) 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.

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

(AA) 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.

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

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

(DD) Facility fiscal year. A facility’s twelve- (12-) month fiscal reporting period. If the facility is also participating in the Title XVIII Medicare (Medicare) program, the Medicaid cost report period shall be the same as the Medicare cost report period. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility’s accounting and reporting period.

(EE) Facility size. The number of licensed nursing facility beds as determined from the cost report.

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

(GG) 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.

(HH) Hospital based. Any nursing facility bed licensed and certified which is physically connected to or located in a hospital.

(I) 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, and ninety-five percent (95%) of the median per diem for the capital cost component.

1. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on July 1, 2022, for the initial 2019 rate base year.

2. Beginning with the SFY 2025 rebase, the median per diem for capital will be determined from the capital component per diems of providers included in the data bank.

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

(KK) Minimum Data Set (MDS). A standardized, primary, and comprehensive tool used to assess a patient’s functional, medical, psychosocial, and cognitive status for residents of nursing facilities to participate in Medicare and Medicaid.

1. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this rule.

2. Assessments should comply with CMS guidance as provided through the Resident Assessment Instrument (RAI) Manual in effect at the time of the assessment.

3. CMS is the only source for MDS data. All MDS initial submissions, corrections, etc., must be submitted through the CMS iQIES according to CMS procedures.

4. MDS reviews. Beginning July 1, 2024, the division or its authorized contractor shall conduct reviews of a facility’s MDS data to verify that residents have been properly classified and that the facility is following CMS procedures and documentation requirements.

A. The general timeline is for MDS reviews to be performed on selected assessments contained in the most recently finalized resident listing at the start of the MDS review quarter, with the quarterly review periods and assessments continually being updated quarterly. For example, MDS reviews completed by the division or its authorized contractor during the January – March 2026 quarter will primarily review MDS assessments contained in the October 2025 final resident listing. MDS reviews completed by the division or its authorized contractor during the April – June 2026 quarter will primarily review MDS assessments contained in the January 2026 final resident listing.

B. The division or its authorized contractor will contact a facility that is the subject of an MDS review at least five (5) business days prior to the review.

C. An entrance conference will be held at the beginning of each day of the MDS review. The facility will be provided a list of MDS assessments to be reviewed that day for which the facility must provide documentation to support the assessment.

(I) A facility liaison will be required to locate, navigate, or otherwise assist with medical record documentation requested by the Registered Nurse (RN) Reviewer(s).

(II) Only the original legal medical record supported documentation will be accepted.

(III) Creating or altering original legal medical record supporting documentation before, during, or after the case mix review is not permissible. Suspected intentional alteration of or creation of supporting documentation after MDS assessments have been completed and transmitted or during the case mix review shall be reported to the Missouri Department of Social Services and referred to the Medicaid Fraud Control Unit of the Attorney General’s Office of Missouri for investigation of possible fraud. Such an investigation could result in a felony or misdemeanor criminal conviction. In addition, the state may exercise the right to complete an additional review.

D. An exit conference will be held at the end of each day of the MDS review to discuss the preliminary results of the review completed that day.



(I) No new, additional information will be accepted for MDS assessments completed that day after the exit conference begins.

E. Informal reconsideration request. If a facility disagrees with the MDS review findings, a written request for an informal reconsideration must be submitted to the division or its authorized contractor within fifteen (15) business days following the close of the MDS review (i.e., after the last exit conference). Otherwise, the results of the MDS review findings are considered final.

(I) If an informal reconsideration request is submitted, it must contain specific details surrounding which MDS review findings the facility disagrees with and the reasons or justifications behind those disagreements.

(II) Only documentation submitted during the initial review may be considered in the reconsideration request and no new documentation may be presented.

(III) Reconsiderations of MDS review findings not filed in accordance with the above timeline, and only filed at the issuance of the recalculated per diem rate or posting of the revised final resident listing, will not be considered.

(IV) The division or its authorized contractor will review the facility's informal reconsideration request within fifteen (15) business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility.

F. After the close of the MDS review, the division or its authorized contractor shall submit its findings in an MDS Review Summary letter to the facility within twenty (20) business days following the final exit conference date. If the facility submitted an informal reconsideration request, the MDS Review Summary letter may be delayed.

G. Validation Improvement Plan (VIP). If the results of the MDS review indicate a substantial percentage of unsupported assessments, the facility may be required to complete a Validation Improvement Plan (VIP). If required, the details and guidelines for a VIP will be outlined in the MDS Review Summary letter. Should a facility not follow the VIP requirements, additional action may be taken by the division, such as an expedited subsequent MDS review.

H. MDS submissions that are not correct will be adjusted and will be used to recalculate the PDPM and associated CMI. A revised final resident listing with the corrected PDPM assessment classification and recalculated CMI for the period under MDS review will be prepared and issued to the facility upon completion of the MDS review process, or upon completion of the informal reconsideration process, if applicable.

I. Rate adjustments.

(I) A facility's per diem rate will be adjusted based on the revisions to the PDPM and associated CMI after the initial training and education period, as set forth below in section (12) of this rule.

(II) MDS reviews completed on assessment data contained in the January and April final resident listings may impact July 1 per diem rates.

(III) MDS reviews completed on assessment data contained in the July and October final resident listings may impact January 1 per diem rates.

(LL) Minimum utilization days. Calculated number of patient days, based on the minimum utilization percentage, which will be used in the determination of the facility's administration and capital cost component per diems if the facility's occupancy is below the minimum utilization percent set forth in subsection (7)(N). Minimum utilization days are calculated by multiplying the facility's bed days by the minimum utilization percent set

forth in subsection (7)(N).

(MM) 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.

(NN) 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)(N) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

(OO) Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2). Guidelines and policies to implement Medicare (Title VIII) regulations which set forth principles for determining the reasonable cost of provider services.

1. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this rule as published by the Centers for Medicare & Medicaid Services (CMS) at its website <https://www.cms.gov/Regulations-and-Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> and <https://www.cms.gov/Regulations-and-Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935>, June 29, 2022. This rule does not incorporate any subsequent amendments or additions.

2. The federal regulations 42 CFR 413 forming the basis of the Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this rule as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1>, June 29, 2022. This rule does not incorporate any subsequent amendments or additions.

3. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) shall be referred to as the Medicare PRM throughout this regulation.

(PP) 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.

1. HIV nursing facility. A nursing facility that operates exclusively for persons with the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) and that was granted an exemption from Certificate of Need under section 197.316, RSMo.

2. New MO HealthNet nursing facility. A qualified facility not previously certified for participation in the Medicaid program within the last twenty-four (24) months. A new MO HealthNet nursing facility shall be given an interim reimbursement rate until a prospective rate is established on its rate setting cost report. A facility previously Medicaid certified within the last twenty-four (24) months (i.e., a facility that terminated participation in the MO HealthNet program and subsequently re-enrolled in the MO HealthNet program) is not considered to be a new MO HealthNet nursing facility regardless of any



changes, including but not limited to a change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. This includes replacement facilities, which are newly constructed facilities with 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.

(QQ) Occupancy rate. The occupancy rate is the percentage of a facility's capacity that is occupied by patients. This may also be referred to as occupancy, utilization, or utilization rate.

1. Total occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the cost report. For a distinct part facility that only has part of its total licensed beds certified for participation in the MO HealthNet program and that completes a worksheet one of the cost report, the occupancy rate is determined by dividing the total actual patient days from the certified portion of the facility by the total bed days from the certified portion for the same period from the cost report.

2. Medicaid occupancy rate. A facility's Medicaid patient days divided by the total patient days for the same period as determined from the cost report.

(RR) Patient care. This cost component includes costs reported in the cost report on lines 46-70.

(SS) 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.

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

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

(VV) Prospective rate. The MO HealthNet reimbursement rate determined from the rate setting cost report.

(WW) Rate setting period or rate base year. The period in which a facility's MO HealthNet'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 or rate base year cost report.

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

(YY) 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 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; and

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

(ZZ) 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.

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

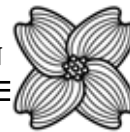
(BBB) Unrestricted funds. Funds, cash, cash equivalents, or marketable securities, including grants, gifts, taxes, and income from endowments that are given to a provider without restriction by the donor as to their use.

(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 that 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) Supplies, items, and services required by federal or state law or regulation that must be provided by nursing facilities participating in the Title XIX program;

(B) Room and board. A private room must be provided, at no additional charge, if it is necessary to isolate a participant due to a medical or social condition, examples of which may be contagious infection or loud irrational speech;

(C) Temporary leave of absence days for Medicaid participants, 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 participant's plan of care and prescribed by a physician. Periods of time during which a participant is away from the facility visiting a friend or relative are therapeutic home leave days and considered temporary



leaves of absence. Hospital leave days, as defined in 13 CSR 70-10.070, are also considered temporary leaves of absence and each hospital leave day is counted as two (2) temporary leave of absence days in determining the twelve (12) allowable leave days for each six- (6-) month period described above;

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

(E) All laundry services, including personal laundry;

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

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

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

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

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

(K) All non-legend antacids, non-legend laxatives, non-legend stool softeners, and non-legend vitamins. Providers may not elect which non-legend 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.

(6) Non-covered Supplies, Items, and Services. Non-covered supplies, items, and services include but are not limited to the following:

(A) Supplies, items, and services which are not covered in a facility's reimbursement rate;

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

(C) Supplies, items, and services that are billable to Medicare or other third-party payer; and

(D) Supplies, items, and services provided non-routinely 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 cost report period in accordance with the guidelines published in the Medicare PRM, Part 1, Section 906.4.

(B) Covered supplies, items, and services 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 that are a necessary part of the operation of a nursing facility and are limited as follows: 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. Vehicles subject to the limit include cars, trucks, vans, sport utility vehicles (SUVs), and shuttle buses. Golf carts, utility terrain vehicles (UTVs), all terrain vehicles (ATVs), and other vehicles not aforementioned in this subsection shall not be included in the total vehicle count for the limit. If the number of vehicles exceeds the limit, the oldest vehicle(s) based on the date the facility acquired the vehicle(s), and the associated costs, are allowable. 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 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 134 of CR (3-95).

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

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

5. Personal property taxes. Personal property taxes related to allowable vehicles shall be reported 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 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 107 of CR (3-95).

2. Other insurance. Liability, umbrella, and other general insurance for the nursing facility should be reported on 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) 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), and (G). Lease expenses shall be reported on line 103 of the CR (3-95). A facility operating its building under a capital 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.

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

(H) 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.

(I) 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.

(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, except for costs associated with nurse aide training and competency evaluation program which the facility may be reimbursed for under 13 CSR 70-10.120 Reimbursement for Nurse Assistant Training.

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

(K) Organizational Costs.

1. Organizational cost items include 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.

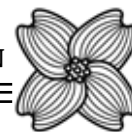
3. Where a provider is organized within a five- (5-) year period prior to its entry into the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational 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 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 are allowable. The costs must be a common and accepted occurrence for providing nursing facility 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 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.

(N) Minimum Utilization. In the event the occupancy rate



of a facility is below eighty percent (80%), the administration and capital cost components will be adjusted as though the provider experienced eighty percent (80%) 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 percent (80%), the total allowable costs are divided by the minimum utilization days rather than the facility's actual patient days. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(O) Home Office or Management Company Costs. The allowability of the individual cost items contained within home office (also known as central office) or management company costs will be determined in accordance with all other provisions of this regulation. The total of home office and/or management company costs, as reported on lines 121 and 122 of CR (3-95), are limited to seven percent (7%) of gross revenues less contractual allowances.

(P) 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 CR (3-95).

(Q) Reusable Items. Costs incurred for items such as linen and bedding shall be classified as inventory when purchased and expensed as the item is used.

(R) Nursing Facility Reimbursement Allowance (NFRA). 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, owners, and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Non-covered supplies, items, and services as defined in section (6);

(P) Owner's compensation in excess of the applicable range of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers and based upon the total number of working hours.

1. Following is the division's 2019 Owner Compensation Guidelines. The division's 2019 Owner Compensation Guidelines shown below shall be updated annually using the CMS Market Basket Index for Wages (i.e., *IHS Markit/Healthcare Cost Review* publication, "Table 6.7 CMS Nursing Home without Capital Market Basket," and the "Wages -%MOVAVG" index).

Owner Compensation Guidelines				
Year	Bed Size	Low	High	Median
2019	0 - 74	\$55,917	\$100,415	\$71,552
	75 - 99	\$42,080	\$102,208	\$72,151
	100 - 149	\$60,132	\$121,451	\$78,162
	150 - 200	\$62,536	\$122,652	\$96,202
	200+	\$72,151	\$180,379	\$99,203

2. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. Owners acting as 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.

3. 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 supplies, items, 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 non-routinely to residents for personal comfort or convenience;

(U) Salaries, wages, or fees paid to nonworking 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 which the facility may be reimbursed for under 13 CSR 70-10.120 Reimbursement for Nurse Assistant Training; 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 participants;
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 will be offset.

B. For purposes of determining reimbursement, the total therapy revenues reported on Schedule A, lines 12, 13, and 16 that are offset shall not exceed the total therapy expenses reported on Schedule B, lines 72-75 and lines 78-79.

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 Recordkeeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve- (12-) month fiscal period for completing its Medicaid cost report as is used for its Medicare cost report, if the facility also participates in the Medicare program. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

2. Each provider is required to complete and submit to the division or its authorized contractor an annual cost report, including all worksheets, attachments, schedules, and requests for additional information from the division or its authorized contractor. The cost report shall be submitted on forms provided by the division or its authorized contractor for that purpose. Any substitute or computer-generated cost report must have prior approval by the division or its authorized contractor.

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. A provider may request, in writing, a reasonable extension of the cost report filing date if there has been an extension granted for its Medicare cost report, if applicable, or for circumstances that are beyond the control of the provider and that are not a product or result of the negligence or malfeasance of the nursing facility. Such circumstances may include public health emergencies; unavoidable acts of nature such as flooding, tornado, earthquake, lightning, hurricane, natural wildfire, or other natural disaster; or, vandalism and/or civil disorder. The division may, at its discretion, grant the extension.

6. If a cost report is more than ten (10) days past due, payment may 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 or its authorized contractor. 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 authorized contractor;

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 authorized contractor;

G. Leases and/or rental agreements related to the activities of the provider, if requested by the division, the department, or its authorized contractor;

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

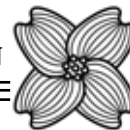
K. Statement verifying the restrictions as specified by the donor, prior to donation, for all restricted grants;

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 contractor 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:

A. Hospital-based providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX participants, relative to their fiscal year;

B. Change in provider status. The cost report filing requirement for the cost report relating to the terminating provider from a change of control, ownership, or termination of participation in the MO HealthNet program is not required, unless the terminating cost report is a full twelve- (12-) month cost report. The division may waive the cost report filing requirement for the twelve- (12-) month terminating cost report or the last twelve- (12-) month fiscal year end 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 request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report.

(I) If a cost report for a year that is used to calculate per diem rates is not submitted, the cost report for the year prior to the rate setting year shall be used to determine the per diem rate, consistent with subsection (4)(V) of this rule.

(II) The new provider may obtain the data needed to prepare a cost report that covers the period that the old/terminating provider operated the facility and may submit a cost report as follows:

(a) The new provider may prepare and submit a cost report that covers the old/terminating provider's cost report period;

(b) The new provider may combine the data from the old/terminating provider with the data from the new provider and submit a twelve- (12-) month cost report that covers the new provider's cost report period, if it occurs in the same year as the old owner;

(c) The new provider must notify the division of its intention to complete a cost report covering the old provider's cost report period including the cost report period that will be submitted;

(d) The cost report is due by the first day of the sixth month following the close of the cost report period, consistent with paragraph (10)(A)5. of this rule, regardless of whether the cost report covers only the old/terminating provider's cost report period or it covers the new provider's cost report period; and

(e) It is the new provider's responsibility to determine if the old/terminating provider will submit a cost report and to obtain any information it needs; and

C. New MO HealthNet facility or recertified MO HealthNet facility. The first cost report for a new facility enrolled in the MO HealthNet program or a facility that had terminated from participation in the MO HealthNet program and was recertified in the MO HealthNet program may not be required if it is a short period cost report. A short period cost report covers three (3) months or less of nursing facility services for MO HealthNet participants, relative to the facility's fiscal year.

(I) If the provider participates in the Medicare program, the provider must complete the MO HealthNet cost report covering the same period as the Medicare cost report unless a short period cost report would still be required by Medicare but is not required by MO HealthNet because it covers

three (3) months or less. For example –

(a) Example A: A facility enters the Medicaid/Medicare program on December 20 and has a December 31 fiscal year end. If Medicare requires that the December 20 – December 31 period be combined with the subsequent year cost report, then the MO HealthNet cost report should cover the same period; and

(b) Example B: A facility enters the Medicaid/Medicare program on October 20 and has a December 31 fiscal year end. If Medicare requires that a cost report be submitted for October 20 through December 31, the facility may request that the division waive that cost report for MO HealthNet since it is within the three- (3-) month short period. The division must approve the request to waive the cost report.

(II) If the facility does not participate in Medicare, the facility must contact the division regarding the treatment of the short period cost report and the division must approve such treatment. The provider may –

(a) Submit the short period cost report; or

(b) Combine the short period with the cost report for the subsequent year; or

(c) Choose not to submit information relating to the short period either on a stand-alone cost report basis or combined with the subsequent year cost report.

11. Notification of change in provider status and withholding of funds for a change in provider status. A provider shall notify the Institutional Reimbursement Unit of the division via email at IRU.NursingFacility@dss.mo.gov prior to a change of control, ownership, or termination of participation in the MO HealthNet program. The division may withhold funds due to a change in provider status as follows:

A. If the division receives notification prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division may withhold funds from the old/terminating provider's remaining payments for any amounts owed to the division including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the provider owes, the division may withhold that amount from the old/terminating provider's remaining payments. If the division cannot determine the amount a provider owes, it may withhold a minimum of thirty thousand dollars (\$30,000) of the remaining payments from the old/terminating provider. After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits; or

B. If the division does not receive notification prior to a change of control or ownership, the division may withhold funds from the provider identified in the current MO HealthNet participation agreement for any amounts owed to the division from the old/terminating provider, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the old/terminating provider owes, the division may withhold that amount from the current provider's payments. If the division cannot determine the amount the old/terminating provider owes, it may withhold a minimum of thirty thousand dollars (\$30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement. If the MO HealthNet payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. After six (6) months, any payments withheld will be released to the provider identified in the current MO HealthNet participation agreement, less any amounts owed



to the division, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits.

(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. 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 AND FEDERAL LAW.

CERTIFICATION OF 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) 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.

AUTHORIZED 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 contractor 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 contractor 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 contractor 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 a Level III Audit (also known as a field audit) by the division or its authorized contractor.

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.

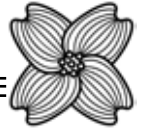
3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized contractor 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 MO HealthNet 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 MO HealthNet 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. The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first full twelve- (12-) month cost report. If a provider terminates prior to the date that the independent audit is due, the independent audit is not required.

(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) Prospective Rate Determination. The division will use the rate setting cost report described in subsection (11)(I) to determine the nursing facility's prospective rate, as detailed in subsections (11)(A)-(I) below.

(A) Patient Care. Each nursing facility's patient care per diem shall be calculated as follows –

1. The base patient care per diem shall be the lower of the –

A. Allowable cost per patient day for patient care as determined by the division from the rate setting cost report, including applicable adjustments and trends; or

B. Per diem ceiling of one hundred twenty percent (120%) of the patient care median determined by the division from the data bank;

2. The base patient care per diem determined in paragraph (11)(A)1. shall be adjusted by the facility's average Medicaid CMI from the two (2) preceding quarterly calculations relative to the effective date of the rate (i.e., for 2019 rebase rates effective July 1, 2022, the January 1, 2022, and April 1, 2022, CMI calculations shall be used) and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate; and

3. Following is an illustration of the calculation of the patient care per diem:

Description		Total Allowable Cost	Ceiling	Lower of Ceiling / Per Diem
Total Patient Care Costs		\$3,285,275		
Aides & Orderlies	\$918,303			
Dietary Salaries	\$248,776			
Total	\$1,167,079			
Salary Adjustment	2%	\$23,342		
Adjusted Patient Care		\$3,308,617		
Trend		7.69%		
Trended Cost		\$3,563,050		
Statewide Average Total CMI	.8744			
Cost Report Total CMI	.9664			
Total CMI Adjusted Costs (\$3,563,050* .8744/.9664)		\$3,223,852		
Total Patient Days		30,475		
Base Patient Care Per Diem		\$105.79	\$127.12	\$105.79
Medicaid CMI	.8206			
Medicaid CMI Adjusted Patient Care Per Diem (\$105.79* .8206/.8744)				\$99.28

(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 adjustments and trends; or

2. Per diem ceiling of one hundred twenty percent (120%) of the ancillary median determined by the division from the

data bank;

3. Following is an illustration of the calculation of the ancillary per diem:

Description		Total Allowable Cost	Ceiling	Lower of Ceiling / Per Diem
Total Ancillary Costs		\$454,281		
Laundry Salaries	\$58,002			
Housekeeping Salaries	\$137,329			
Beauty & Barber Salaries	\$0			
Total	\$195,331			
Salary Adjustment	2%	\$3,907		
Adjusted Ancillary		\$458,188		
Trend		7.69%		
Trended Cost		\$493,423		
Total Patient Days		30,475		
Ancillary Per Diem		\$16.19	\$21.48	\$16.19

(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)(N); 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)(N);

3. Following is an illustration of the calculation of the administration per diem:

Description		Total Allowable Cost	Ceiling	Lower of Ceiling / Per Diem
Total Administration Costs		\$1,772,163		
Trend		7.69%		
Trended Cost		\$1,908,442		
Total Patient Days	30,475			
Minimum Utilization Days	44,384			
Greater of Total Patient Days or Min. Utilization Days		44,384		
Administration Per Diem		\$43.00	\$35.73	\$35.73

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which



consists of two (2) elements – rental value 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.–3.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report. The changes in the number of licensed beds (i.e., increases and decreases) from the date the facility was originally licensed through the end of the rate setting cost report period should be determined and should result in the same number of licensed beds at the end of the facility's rate setting cost report.

(a) Facility size and occupancy rate adjustment. Beginning with the SFY 2025 rebase, a facility may request a facility size and occupancy rate adjustment, which provides for the number of licensed beds as of the April 1 that precedes the July 1 rate calculation to be used to determine the facility size and occupancy rate rather than the number of licensed beds at the end of the applicable cost report period.

I. 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 operated at less than its licensed bed capacity during the cost report period used to determine the facility's capital rate so that it could provide single occupancy accommodations;

b. The facility operated as such at least from the beginning of the facility's cost report period used to determine the facility's capital rate through the April 1 that precedes the July 1 rate calculation; and

c. The facility reduced the number of licensed beds to be equal to the number of single occupancy rooms that the facility will operate with going forward. The reduction in licensed beds must be effective on or before the April 1 that precedes the July 1 rate calculation.

II. 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)(EE) of this rule and used in the determination of a facility's capital cost component under the fair rental value system set forth in subsection (11)(D) of this rule shall be adjusted to reflect the licensed bed capacity as of the April 1 that precedes the July 1 rate calculation.

b. Adjusted occupancy rate. The occupancy rate as defined in subsection (4)(QQ) of this rule shall be adjusted to reflect the licensed beds as of the April 1 that precedes the July 1 rate calculation rather than the licensed beds reflected on the applicable cost report. The bed days will be calculated using the licensed beds as of the April 1 that precedes the July 1 rate calculation and the adjusted occupancy rate will 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.

III. The facility must request in writing the facility size and occupancy rate adjustment and provide the proper documentation to show that it qualifies for the adjustment, including the following:

a. A copy of the quarterly surveys from the beginning of the applicable cost report period through the April 1 that precedes the July 1 rate calculation showing that the facility's number of available beds was less than its full

licensed bed capacity;

b. A copy of the approved change in the number of licensed beds that includes a notation that the rooms are single occupancy;

c. A statement from the facility that it will continue to operate single occupancy rooms; and

d. For the July 1, 2024, rate calculation, the division shall accept such written requests from facilities that qualify for this adjustment as of July 1, 2024, for up to thirty (30) days after the effective date of this rule. The rate adjustment shall be retroactive back to July 1, 2024. For subsequent rate calculations, a facility must submit the request, including all documentation showing that they qualify for the adjustment, to the division by the May 1 that precedes the July 1 rate calculation, and the rate adjustment shall be effective on July 1.

IV. This adjustment shall only apply to nursing facilities with a prospective rate and shall remain in effect for all subsequent rates determined from the 2022 cost report used to rebase rates.

V. Loss of facility size adjustment and recalculation of per diem rate. If a facility's per diem rate has been calculated using an adjusted facility size and an adjusted occupancy rate and the facility ceases to operate with only single occupancy accommodations, the facility will no longer receive the adjustment to the facility size and occupancy rate in determining its per diem rate.

a. If the facility size and occupancy rate adjustment is lost, the facility's per diem rate will be recalculated using the facility size as set forth in subsection (4)(EE) and the bed days and occupancy rate as set forth in subsection (4)(QQ) of this rule.

b. The facility must notify the division within thirty (30) days if it no longer qualifies for the facility size and occupancy rate adjustment.

c. If the facility notifies the division of such within thirty (30) days, the effective date of the rate recalculation will be the date that the facility stopped operating with only single occupancy accommodations.

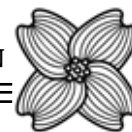
d. If the facility does not notify the division within thirty (30) days, the effective date of the rate recalculation will be the date the facility size and occupancy rate adjustment was originally granted. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

(II) Determine the bed equivalency for capital expenditures from the date the facility was originally licensed through the end of the rate setting cost report period by taking the cost of the capital expenditures for each year divided by the asset value per bed for the year of the capital expenditures rounded down to the nearest whole bed. The cost of the capital expenditures must be at least the asset value per bed for the year of the capital expenditures for each bed equivalency. For example, a capital expenditures done in 2009 with a cost of two hundred seventy thousand dollars (\$270,000) is equal to five (5) beds. (\$270,000/\$47,948 equals 5.65 beds rounded down to 5 beds).

(III) The Total Facility Size is the sum of (I) and (II).

(IV) 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 rate base year. The age of bed equivalencies for capital expenditures is calculated by subtracting the year the capital expenditures were made from the year relative to the rate base year. The age of the beds for



multiple licensing dates (i.e., for increases and decreases in licensed beds) and multiple bed equivalencies is calculated on a weighted average method rounded to the nearest whole year. For licensed bed decreases and replacement beds, the oldest beds are delicensed first. 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%).

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 six and three hundred seventy-fifths percent (6.375%) to determine the rental value. The six and three hundred seventy-fifths percent (6.375%) is comprised of two and one-half percent (2.5%), which is based on a forty- (40-) year life, plus three and eight hundred seventy-fifths percent (3.875%) for a return. The three and eight hundred seventy-fifths percent (3.875%) is based on the Treasury Bill thirty- (30-) year coupon rate in effect as of January 1, 2022, of one and eight hundred seventy-fifths percent (1.875%) plus two percent (2%).

E. The following is an illustration of how subparagraphs (11)(D)1.A., B., C., and D. determine the rental value.

(I) The following is the determination of the total facility size and the age of the beds:

Historical Base Data *			
	Total Facility Size	Age	Age x Beds
Licensed Beds	75		
Bed Equivalents	0		
Totals	75	30	2,250

* This is the cumulative, historical data previously used to determine existing nursing facilities' prospective rates under 13 CSR 70-10.015.

Licensure History *				
Licensure Year		No. of Bed Incr/(Decr)	Age From 2019	Age x Beds
Bed Increases / Decreases:	2003	15	16	240
	2004	5	15	75
	2006	10	13	130
	2008	(5)	30	(150)
	Totals (Bed Incr/(Decr thru 2019))	25		295
Total Licensed Beds (Base Data + Bed Incr/(Decr))		100		

* This is the licensure history from 2002-2019 which reflects the licensure changes subsequent to the Historical Base Data shown above.

Capital Expenditure History *					
Year	Allowable Capital Expenditures for Bed Equiv	Asset Value – Year of Capital Expenditures	Bed Equivalents	Age From 2019	Age x Beds
2002	\$1,677,164	\$35,325	47	17	799
2009	\$170,824	\$47,948	3	10	30
2014	\$310,351	\$52,042	5	5	25
2018	\$84,308	\$53,769	1	1	1
2019	\$145,692	\$64,701	2	0	0
Totals (Bed Equiv. through 2019)			58		855
Total Bed Equiv. (Base Data + Bed Equiv thru 2019)			58		

* This is the capital expenditure and bed equivalency history from 2002-2019 which reflects the changes subsequent to the Historical Base Data shown above.

Total Facility Size and Weighted Average Age		
Total Facility Size (Licensed Beds + Bed Equiv.)	158	3,400
Weighted Average Age (3,495 / 158)		22

(II) The total asset value is the product of the total facility size times the asset value.

Total facility size	158
x Asset value - 2019	\$64,701
Total asset value	\$10,222,758

(III) Facility asset value is total asset value less the reduction for age of the beds.

Total asset value	\$10,222,758
x Age of beds x 1%	22%
- Reduction for age (max 40%)	(\$2,249,007)
Facility asset value	\$7,973,751

(IV) Rental value is the facility asset value multiplied by 6.375%.

Facility asset value	\$7,973,751
x Rental value percent	x 6.375%
Rental value	\$508,327

2. Pass-through expenses.

A. Add the following pass-through expenses, including applicable trends:

- (I) Property insurance – line 107 of CR (3-95);
- (II) Real estate taxes – line 108 of CR (3-95); and
- (III) Personal property taxes – line 109 of CR (3-95).

3. Capital component per diem calculation. A per diem is calculated for each element detailed above in paragraphs (11)(D) 1.–2., which are then added together to determine the total capital cost component per diem.

A. Rental value per diem. A per diem is calculated by dividing the rental value 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.(III) multiplied by three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(N) or the facility's occupancy from the rate setting cost report. The following is an illustration of how the rental value per diem is calculated:

	Allowable Cost	Computed Patient Days *	Per Diem
Rental Value	\$508,327	46,136	\$ 11.02
* Computed Patient Days:			
Total facility size		158	
x 365 days		x 365	
Subtotal		57,670	
Greater of:			
Minimum Utilization	80.00%		
Facility Occupancy **	56.63%	x 80.00%	
Computed Patient Days		46,136	

** Assumption: facility occupancy from the rate setting cost report = 56.63%

B. Pass-through expenses per diem. A per diem is calculated by dividing the pass-through expenses by the greater of the minimum utilization days as determined in subsection (7)(N) or the facility's patient days from the rate setting cost report, rounded to the nearest cent. The following is an illustration of how the pass-through per diem is calculated:

	Allowable Cost	Patient Days *	Per Diem
Pass-Through Expenses:			
Property Insurance	\$23,969		
Real Estate Taxes	\$61,962		
Personal Property Taxes	\$3,408		
Total Pass-Through Expenses	\$89,339		
Trend	7.69%		
Total Trended Pass-Through Expenses	\$96,209	43,050	\$2.23
* Patient days - Greater of:			
a. Facility patient days		30,475	
b. Minimum utilization days			
Beddays		53,812	
x Minimum Utilization Percent		x 80%	
Minimum utilization days		43,050	

C. The capital cost component per diem is the sum of the per diems determined in subparagraphs (11)(D)3.A. and B.

Rental value	\$11.02
Pass-through expenses	\$ 2.23
Total capital cost component per diem	\$13.25

(E) The following is an illustration of how subsections (11)(A)–(D) determine the total per diem for the cost components:

Cost Component	Per Diem
Patient Care	\$99.28
Ancillary	\$16.19
Administration	\$35.73
Capital (FRV)	\$13.25
Total Cost Component Per Diem	\$164.45

(F) Special Per Diem 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 July 1, 2022, shall receive a per diem adjustment equal to four and seventy-fifths percent (4.75%) of the facility's patient care per diem determined in paragraph (11)(A)1. 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 paragraph (11)(A)1. This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Multiple component incentive. Each facility with a prospective rate on or after July 1, 2022, 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 (11)(B), is greater than or equal to seventy percent (70%), rounded to four (4) decimal places (.6985 would not receive the adjustment) of the facility's total per diem, the adjustment is as follows:

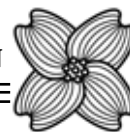
Patient Care & Ancillary Percent of Total Rate	Incentive
< 70%	\$0.00
> or = 70% but < 75%	\$0.10
> or = 75% but < or = 80%	\$0.15
> 80%	\$0.20

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (11)(F)2.A. and if the facility's Medicaid utilization percent is greater than eighty-five percent (85%), rounded to four (4) decimal places (.8485 would not receive the adjustment). The adjustment is as follows:

Medicaid Utilization Percent	Incentive
< 85%	\$0.00
> or = 85% but < 90%	\$0.10
> or = 90% but < 95%	\$0.15
> or = 95%	\$0.20

3. Value Based Purchasing (VBP) Incentive. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. The facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets. The threshold for each QM is based on national cut-points used by CMS in its Five-Star Rating System. Each threshold is the maximum QM value a facility can have in order to receive the per diem adjustment. These thresholds are listed in Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017. The thresholds listed in Table A3 have been rounded to the nearest tenth for purposes of determining the



VBP Incentive. Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017 is incorporated by reference and made a part of this rule as published by CMS and available at <https://dss.mo.gov/mhd/providers/nursing-home-reimbursement-resources.htm>. This rule does not incorporate any subsequent amendments or additions.

(I) SFY 2023 QM Performance Measure Table. The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022, is used to determine the per diem adjustment(s) the facility qualified to receive for the rates effective July 1, 2022. The QM Performance Measure threshold, rounded to the nearest tenth, and per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Adjustment		
Decline in Late-Loss ADLs	< or = 10.0%	\$1.00
Decline in Mobility on Unit	< or = 8.0%	\$1.00
High-Risk Residents w/ Pressure Ulcers	< or = 2.7%	\$1.00
Anti-Psychotic Medications	< or = 6.8%	\$1.00
Falls w/ Major Injury	< or = 1.3%	\$1.00
In-Dwelling Catheter	< or = 1.1%	\$1.00
Urinary Tract Infection	< or = 1.9%	\$1.00

(II) SFY 2024 QM Performance Measure Table. Effective for dates of service beginning July 1, 2023, the QM Performance Measure per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	< or = 10.0%	\$1.87
Decline in Mobility on Unit	< or = 8.0%	\$1.87
High-Risk Residents w/ Pressure Ulcers	< or = 2.7%	\$1.87
Anti-Psychotic Medications	< or = 6.8%	\$1.87
Falls w/ Major Injury	< or = 1.3%	\$1.87
In-Dwelling Catheter	< or = 1.1%	\$1.87
Urinary Tract Infection	< or = 1.9%	\$1.87

(III) SFY 2025 QM Performance Measure Table. Effective for dates of service beginning July 1, 2024, the QM Performance Measure per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs	< or = 10.0%	\$3.04
Decline in Mobility on Unit	< or = 8.0%	\$3.04
High-Risk Residents w/ Pressure Ulcers	< or = 2.7%	\$3.04
Anti-Psychotic Medications	< or = 6.8%	\$3.04
Falls w/ Major Injury	< or = 1.3%	\$3.04
In-Dwelling Catheter	< or = 1.1%	\$3.04
Urinary Tract Infection	< or = 1.9%	\$3.04

(IV) SFY 2026 QM Performance Measure Table. Effective for dates of service beginning July 1, 2025, the QM Performance Measures and related per diem adjustments are as follows:

QM Performance	Threshold	Per Diem Adjustment
Decline in Late-Loss ADLs (percentage of long-stay residents whose need for help with daily activities has increased)	< or = 10.0%	\$3.42
Decline in Mobility on Unit (percentage of long-stay residents whose ability to walk independently worsened)	< or = 8.0%	\$3.42
High-Risk Residents w/ Pressure Ulcers (percentage of high risk long-stay residents with pressure ulcers)	< or = 2.7%	\$3.42
Anti-Psychotic Medications (percentage of long-stay residents who received an antipsychotic medication)	< or = 6.8%	\$3.42
Falls w/ Major Injury (percentage of long-stay residents experiencing one (1) or more falls with major injury)	< or = 1.3%	\$3.42
In-Dwelling Catheter (percentage of long-stay residents with a catheter inserted and left in their bladder)	< or = 1.1%	\$3.42
Urinary Tract Infection (percentage of long-stay residents with a urinary tract infection)	< or = 1.9%	\$3.42

B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the eight (8) long-stay QMs, as follows:

(I) The eight (8) long-stay QMs included in the total QM score to determine the VBP percentage include the following:

- (a) Decline in Late-Loss ADLs;
- (b) Decline in Mobility on Unit;
- (c) High-Risk Residents w/ Pressure Ulcers;
- (d) Anti-Psychotic Medications;
- (e) Falls w/ Major Injury;
- (f) In-Dwelling Catheter;
- (g) Urinary Tract Infection; and
- (h) Physical Restraints;

(II) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022, is used to determine the facility's QM Score and VBP percentage for the rates effective July 1, 2022;

(III) For each QM value, the corresponding number of QM points will be determined from Table A3 of the *Five-Star Quality Rating System: Technical Users' Guide* dated January 2017;

(IV) The QM points for all of the QMs will be summed to determine the facility's total QM Score; and

(V) The VBP percentage for each scoring range is listed in the following table.



QM Scoring Tier	Minimum Score	VBP Percentage
1	600	100%
2	520	75%
3	440	50%
4	360	25%
5	0	0%

4. Mental illness (MI) diagnosis add-on. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars (\$5.00):

- (I) Schizophrenia; and
- (II) Bi-polar.

(G) Prospective Rate Calculation.

1. A preliminary per diem shall be calculated and is the sum of –

A. The cost component per diems as set forth in subsections (11)(A)-(11)(E); and

B. The patient care incentive and multiple component incentive set forth in paragraphs (11)(F)1. and (11)(F)2., respectively.

2. A base rate shall be determined and is the greater of –

A. The preliminary per diem; and

B. The facility's prospective rate as of June 30, 2022, excluding NFRA.

C. The base rate for new nursing facilities operating under an interim rate, whose initial prospective rate is effective on or after July 1, 2022, is the greater of –

(I) The preliminary per diem; and

(II) The facility's interim rate on the day before the effective date of the initial prospective rate, excluding NFRA.

3. The facility's rebased rate shall be the sum of –

A. The facility's base rate; and

B. The NFRA in effect for the applicable date of service.

4. The facility's prospective rate shall be the sum of –

A. The facility's rebased rate;

B. The VBP Add-On set forth in paragraph (11)(F)3., if applicable; and

C. The Mental Illness Diagnosis Add-On set forth in paragraph (11)(F)4., if applicable.

5. The following is an illustration of how subsections (11)(A)-(G) determine a facility's prospective rate:

Cost Component	Per Diem
Patient Care	\$99.28
Ancillary	\$16.19
Administration	\$35.73
Capital (FRV)	\$13.25
Total Cost Component Per Diem	\$164.45
Patient Care Incentive	\$5.03
Multiple Component Incentive	\$0.10
Total Patient Care & Multiple Component Incentives	\$5.13
Preliminary Per Diem	\$169.58

Current Prospective Rate (excluding NFRA) – June 30, 2022	\$163.98
Base Rate - Greater of Preliminary Per Diem or June 30, 2022 Prospective Rate	\$169.58
NFRA – July 1, 2022	\$12.93
Total Rebased Rate	\$182.51
VBP Incentive	\$2.00
VBP Payment Percent	75%
VBP Add-On Per Diem Rate	\$1.50
Mental Illness Diagnosis Add-On	\$0.00
Total Prospective Rate – July 1, 2022	\$184.01

(H) Semi-Annual and Annual Rate Updates. Each facility with a prospective rate on or after July 1, 2022, shall have its rate updated for the following items as described below:

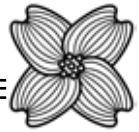
1. Semi-annual acuity adjustment for patient care per diem rate. Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The patient care per diem rate will be adjusted effective for dates of service beginning January 1 and July 1 of each year. The Medicaid CMI will be updated based on the facility's average Medicaid CMI from the two (2) preceding quarterly calculations. The allowable patient care cost per day determined in paragraph (11)(A)1. shall be adjusted by the applicable Medicaid CMI and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate, effective each January 1 and July 1. The applicable Medicaid CMI are as follows:

A. Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations; and

B. Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations;

2. Semi-annual adjustment for VBP Incentive. Each facility's QM Performance data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. For facilities that do not have updated data as of the review date, prior period data will be carried forward. This provision will be applied to data frozen by CMS. A facility must meet the criteria set forth in paragraph (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify;

3. Semi-annual adjustment for mental illness diagnosis add-on. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the final resident listing for October for the January 1 rate adjustment and the final resident listing for April for the July 1 rate adjustment. For facilities that do not



have updated data as of the review date, prior period data will be carried forward. A facility must meet the criteria set forth in paragraph (11)(F)4. each period and will lose any per diem adjustments for which it does not continue to qualify;

4. Annual capital rate update. Each facility's capital rate will be recalculated annually by updating the rental value portion of the capital rate. The capital rate will be recalculated at the beginning of each state fiscal year (SFY), effective for dates of service beginning July 1, as follows:

A. The total facility size will be updated each year for any increases or decreases in licensed beds and capital expenditures that qualify as bed equivalencies, as follows:

(I) For SFY 2024, effective for dates of service beginning July 1, 2023, the total facility size will be updated using information from the 2020 and 2021 cost reports; and

(II) For SFY 2025 forward, the total facility size will be updated using the information from the third prior year cost report relative to the SFY (i.e., for SFY 2025, the facility size will be updated using 2022 cost report data);

B. The weighted average age of the facility shall be updated each year. The age shall be calculated from the year coinciding with the latest cost report used to update the facility size above in subparagraph (11)(A)1.A. (i.e., the age for SFY 2024 shall be calculated from 2021, the age for SFY 2025 shall be calculated from 2022, etc.); and

C. The asset value shall be updated each SFY. The asset value shall be updated for the year coinciding with the latest cost report used to update the facility size above in subparagraph (11)(A)1.A. (i.e., for SFY 2024 the 2021 asset value shall be used, for SFY 2025 the 2022 asset value shall be used, etc.); and

5. A facility's prospective rate shall be increased or decreased based upon the semi-annual and annual rate adjustments, but the rate shall not be decreased below the facility's June 30, 2022, prospective rate.

(I) Rate Setting Cost Report.

1. A facility with a valid Medicaid participation agreement and a prospective rate in effect on June 30, 2022, shall have its prospective rate rebased on its 2019 cost report. If a facility does not have a 2019 cost report, the next available cost report year shall be used as the rate setting cost report.

2. A nursing facility never previously certified for participation in the MO HealthNet program that originally enters the MO HealthNet program after June 30, 2022, shall receive an interim rate, as defined in subsection (4)(JJ), effective on the initial date of MO HealthNet certification. A prospective rate shall be determined in accordance with this regulation from the 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. This prospective rate shall be retroactively effective to the first day of the facility's second full twelve- (12-) month fiscal year and shall replace the interim rate for dates of service beginning on the first day of the facility's second full twelve- (12-) month fiscal year. The following items shall be updated annually and shall be used in determining the prospective rate:

A. Ceilings. The ceiling used to determine the prospective rate shall be the ceiling in effect at the beginning of the rate setting period;

B. Asset Value. The asset value shall be updated annually as set forth in subsection (4)(E). The asset value for the year coinciding with the rate setting cost report year (i.e., the end of the cost report period) shall be used; and

C. Age of Beds and Bed Equivalencies. The age of beds shall be calculated by subtracting the year the beds were

originally licensed from the year coinciding with the rate setting cost report year (i.e., the end of the cost report period). The age of bed equivalencies shall be calculated by subtracting the year the capital expenditures were made from the year coinciding with the rate setting cost report (i.e., the end of the rate setting cost report period).

3. A facility with a valid Medicaid participation agreement in effect after June 30, 2022, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program within two (2) years, 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 (12)(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.

(12) Adjustments to the Reimbursement. 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 70-10.017.

(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 below:

1. SFY 2024 Per Diem Rate Adjustment.

A. Effective for dates of service beginning July 1, 2023, facilities with either an interim rate or a prospective rate in effect on July 1, 2023, shall be granted an increase to their per diem rate of ten dollars and zero cents (\$10.00);

B. Effective for dates of service beginning July 1, 2023, and ending December 31, 2023, the rate to which the SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) shall be added is the facility's July 1, 2023, rate after all rate setting procedures have been applied, including adjustments for the Semi-Annual and Annual Rate Updates set forth in subsection (11)(H) that are effective July 1, 2023, and after selecting the greater of the Preliminary Per Diem or the June 30, 2022, prospective rate (excluding NFRA), and adding the NFRA per diem, VBP incentive, and MI add-on effective July 1, 2023. The increased VBP per diem adjustments effective July 1, 2023, detailed above in part (11)(F)3.A.(II) and shown in the accompanying QM Performance Measure table shall be used in this calculation. The SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) is not added to the facility's June 30, 2022, prospective rate and is not allocated and added to the cost component ceilings in performing this calculation.

C. Subsequent Semi-Annual and Annual Rate Updates. Effective for dates of service beginning with the effective date of the rate change (i.e., January 1 or July 1) and ending on the day prior to the effective date of the next rate change (i.e., December 31 or June 30), the SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) will be added to the facility's rate after all rate setting procedures have been applied, including the Semi-Annual and Annual Rate Updates set forth in subsection (11)(H) that are effective on the date of the rate change, and after selecting the greater of the Preliminary Per Diem or the June 30, 2022, prospective rate (excluding NFRA), and adding the NFRA per diem, VBP Incentive, and MI add-on effective on the date of the rate change. The increased VBP per diem adjustments effective July 1, 2023, detailed above in part (11)(F)3.A.(II) and shown in the accompanying QM Performance Measure table shall be used in this calculation. The SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) is



not added to the facility's June 30, 2022, prospective rate and is not allocated and added to the cost component ceilings in performing this calculation. The SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) shall only be included in the rate once for each effective date; it is not a cumulative adjustment from one effective date to the next.

D. New Nursing Facilities. For new nursing facilities never previously certified for participation in the MO HealthNet program that need to have their prospective rate determined as set forth in subsection (11)(I), the SFY 2024 per diem adjustment of ten dollars and zero cents (\$10.00) will be added to the facility's rate beginning July 1, 2023, in the same manner as detailed above in subparagraphs (12)(A)1.B and (12)(A)1.C.

(B) Extraordinary Circumstances. A participating facility which has a prospective rate may request an adjustment to its reimbursement 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 reimbursement adjustment is sought. The dollar amount of the requested reimbursement 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 reimbursement 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 reimbursement adjustment. In the case of a reimbursement 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, reimbursement adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

1. 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;

2. Extraordinary circumstances, which are beyond the reasonable control of the nursing facility and are not a product or result of the negligence or malfeasance of the nursing facility, include but are not limited to –

A. Unavoidable acts of nature that occur in a federally declared disaster area. Unavoidable acts of nature may include hurricane, flooding, earthquake, tornado, lightning, natural wildfire, or other natural disaster for which no one can be held responsible; or

B. Vandalism and/or civil disorder; and

3. Adjustment to a facility's reimbursement for extraordinary circumstances shall only be for costs that are not covered by insurance. The reimbursement adjustment(s) shall be calculated as follows:

A. For one- (1-) time costs that will not be incurred in future fiscal years –

(I) Costs directly associated with the extraordinary circumstances that have not been covered by insurance will be multiplied by the Medicaid occupancy percent from the latest cost report available for the time period preceding when the extraordinary circumstances occurred; and

(II) This amount will be paid to the facility as a one- (1-) time, lump sum payment;

B. For ongoing costs that will be incurred in future fiscal years –

(I) Ongoing annual costs will be divided by the greater of –

(a) Annualized (calculated for a twelve- (12-) month period) total patient days from the latest cost report on file; or

(b) Minimum utilization days; and

(II) This calculation will be a per diem rate adjustment that will 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

C. For capitalized costs, the capital cost component per diem rate is updated at the beginning of each SFY so any capital expenditures resulting from the extraordinary circumstances will be captured during that annual rate update.

(C) Invasive Ventilator Care Adjustment. 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.

(D) 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;

4. Disallowance of federal financial participation; and

5. MDS reviews.

A. If a facility's MDS submissions were corrected as a result of an MDS review and resulted in a revised CMI, a facility's per diem rate shall be adjusted as follows:

(I) For reviews completed between July 1, 2024, and December 31, 2025, per diem rates will only be adjusted for increases in the CMI;

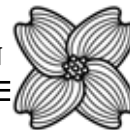
(II) For reviews completed between January 1, 2026, and December 31, 2026, per diem rates will be adjusted for any changes to the CMI. The per diem rate may be increased or decreased based on the adjusted CMI; and

(III) For reviews completed after January 1, 2027, per diem rates will only be adjusted for decreases in the CMI.

B. Per diem rate adjustments and payment adjustments.

(I) The per diem rate will be recalculated using the Medicaid CMI that has been revised based on the corrected MDS submissions.

(II) The revised per diem rate will replace the per diem rate with the incorrect CMI for the period that the incorrect rate was in effect. The revised per diem rate will be retroactive to the initial effective date of the rate being revised and will



remain in place until the effective date of the following rate.

(III) The payments corresponding to the per diem rate with the incorrect CMI will be adjusted to reflect the revised per diem rate including the corrected CMI.

(a) Additional payments will be made to nursing facilities with increases in the per diem rate resulting from the corrected CMI.

(b) Payments will be recouped from nursing facilities with decreases in the per diem rate resulting from the corrected CMI.

(13) Exceptions.

(A) Requirements for Placement of MO HealthNet Participants in Out-of-State Nursing Facilities and Reimbursement for Out-of-State Nursing Facilities.

1. In order to provide nursing facility services to MO HealthNet participants when there is no Missouri nursing facility with a suitable bed available that meets the medical needs of the participant, the division may authorize placement of a MO HealthNet participant in an out-of-state facility.

2. The division will only authorize placement of a MO HealthNet participant into an out-of-state facility if –

A. No Missouri nursing facility bed is available that meets the medical needs of the participant;

B. In-state alternatives for providing services have been exhausted; and

C. Prior approval for placement into an out-of-state nursing facility is requested from and approved by the division.

3. Once a Missouri nursing facility bed meeting the medical needs of the participant is available, the participant must return to Missouri. If the participant does not return to Missouri, the division shall withhold payments for nursing facility services, unless the participant's health would be endangered if required to travel to Missouri. Participant's physician would need to certify that the participant's health would be endangered from the travel to Missouri.

4. No fiscal year-end Missouri Medicaid cost report will be required from the out-of-state nursing facility nor will there be any requirement for Missouri-conducted periodic audits.

5. The Title XIX reimbursement rate for out-of-state providers shall be set as follows:

A. For out-of-state providers which provided services for Missouri Title XIX participants, the reimbursement rate shall be the lower of –

(I) The weighted average MO HealthNet rate for comparable services at the beginning of the state fiscal year in which the provider enters the MO HealthNet program; or

(II) The rate paid to the out-of-state nursing facility for comparable services by the state in which the provider is located. The out-of-state provider must notify the division of any reimbursement changes made by its state Medicaid agency. The provider must also include a copy of the rate letter issued by their state Medicaid agency detailing the rate and effective date. The effective date of the rate change is as follows:

(a) Rate increases – 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 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.

(B) Hospital Based Nursing Facilities.

1. The Title XIX reimbursement rate for hospital based providers that provide services of less than one thousand (1,000) patient days for Missouri Title XIX participants, relative to their fiscal year, and that are exempt from filing a cost report as prescribed in section (10) shall be determined as follows:

A. 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; and

B. The prospective rate will be the sum of the ceilings for the patient care, ancillary, and administration cost components plus the median per diem for capital. In addition, the patient care incentive of four and seventy-five hundredths percent (4.75%) of the patient care median will be granted.

2. For hospital based nursing facilities that provide one thousand (1,000) or more patient days for Missouri Title XIX participants, relative to their fiscal year, 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 the patient care, ancillary, and administration cost components plus the median per diem for capital. In addition, the patient care incentive of four and seventy-five hundredths percent (4.75%) of the patient care median will be granted.

(14) 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.

(15) 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.

(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 participants, the amount paid in accordance with these regulations and other applicable payments.

(17) 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.

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



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, mouth-washes, 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 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, 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 208.159, 208.201, and 660.017, RSMo 2016, and section 208.153, RSMo Supp. 2025. Emergency rule filed May 16, 2023, effective May 31, 2023, expired Nov. 26, 2023. Original rule filed May 16, 2023, effective Dec. 30, 2023. Emergency amendment filed Feb. 21, 2024, effective March 6, 2024, expired Sept. 1, 2024. Amended: Filed Feb. 21, 2024, effective Aug. 30, 2024. Emergency amendment filed Jan. 21, 2025, effective Feb. 4, 2025, expired Aug. 2, 2025. Amended: Filed Jan. 21, 2025, effective Aug. 30, 2025. Amended: Filed Nov. 24, 2025, effective May 30, 2026.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

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.

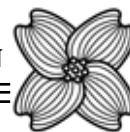
(1) Objectives. This rule establishes a payment plan for nonstate-operated intermediate care facility for individuals with intellectual disabilities (ICF/IID) services.

(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 Medicare per diem rate, if applicable; or
2. The reimbursement rate as determined in accordance with this regulation.



(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.

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

(3) Definitions.

(A) "Allowable Cost Areas" means those cost areas that 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 *Medicare Provider Reimbursement Manual* (HIM-15) and section (6) of this rule.

(B) "Average Private Pay Charge" means 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) "Cost Report" means a report detailing 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 of Social Services.

(D) "Department" means the Missouri Department of Social Services, unless otherwise specified.

(E) "Director" means the director of the Missouri Department of Social Services, unless otherwise specified.

(F) "Effective Date" means November 1, 1986.

(G) "ICF/IID" means nonstate-operated facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

(H) "Medicare Rate" means the allowable cost of care permitted by Medicare standards and principles of reimbursement.

(I) "New Construction" means 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.

(J) "New Owners" means the original owners of new construction.

(K) "Providers" means, under the Prospective Reimbursement Plan, 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.

(L) "Reasonable and Adequate Reimbursement" means reimbursement levels which meet the needs of an efficiently

and economically operated facility and which in no case exceed normal market costs.

(M) "Related Parties" means –

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 have 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" or "Indirect 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 Interest" or "Controlling Interest" means a person or corporation(s) –

(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 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.

(N) "Rural" means those counties that are not defined as urban.

(O) "Urban" means counties that 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) ICF/IID Rate Computation. 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. Rate determination shall be based on 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.

(A) Prospective Reimbursement Rate Determination through December 31, 2018.

1. 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 MO HealthNet Division will use the most current cost report on file with the department to set a facility's per diem rate. Facilities with less than a full twelve- (12-) month 1985 fiscal year will not have their base year rates updated.

2. 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.

3. 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.

4. 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.

5. Prospective payment adjustment (PPA). A FY92 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.

A. For providers that qualify, the PPA shall be the lesser of –

(I) 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 (ICFIIDC) on October 1, 1991 ($FPGF \times PPD \times PPAF \times ICFIIDC$). 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 $3.22\% \times 114,244 \times 24.5\% \times \$156.01 = \$140,607$; or

(II) 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.

B. 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 providers qualifying as of the determination date of October 16, 1991.

C. ICFIIDC – is one hundred fifty-six dollars and one cent (\$156.01) on October 1, 1991.

D. PPAF – is equal to twenty-four and one half percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

E. 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.

6. 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.

7. 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.

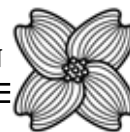
8. FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents (\$6.07) per patient day for the negotiated trend factor. This adjustment is equal to 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).

9. 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).

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

15. 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).

16. 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.

17. 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.

18. 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.

19. 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.

20. 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.

(B) Per Diem Rate Calculation Effective for Dates of Service Beginning January 1, 2019. Effective for dates of service beginning January 1, 2019, the MO HealthNet Division shall rebase nonstate-operated ICF/IID facilities' per diem rates using the facilities' 2017 fiscal year-end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its

prospective rate recalculated based on its 2017 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1)-(13) of this regulation.

(I) The costs from the 2017 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four- (4-) quarter moving average. 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 2019, the trends are as follows:

(a) 2018=3.025%

(b) 2019=2.65%

(II) If a facility's total calculated per diem set forth in this section is less than the facility's current rate, the facility shall continue to receive its current rate.

(III) The division will use the FY 2017 cost report to determine the ICF/IID prospective rate, set forth as follows:

(a) Total Routine Service Cost. Total routine service cost includes patient care, ancillary, dietary, laundry, housekeeping, plant operations, and administration. Each ICF/IID's Title XIX Routine Service Cost per diem shall be calculated as follows:

I. The total routine service costs as reported on the cost report shall be adjusted for minimum utilization, if applicable, trended to the current state fiscal year, and divided by the total patient days to determine the per diem. The minimum utilization adjustment will be determined by applying the unused capacity percent to the sum of the laundry, housekeeping, plant operations, and administration expenses. The following is an illustration of how this item (4) (B)1.A.(III)(a)I. is calculated:

Licensed/Certified Bed Days	
(9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88%
Bed Days @ Minimum Occupancy of 90%	
(3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization Adjustment (Unused Capacity/90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity (Greater of 90% of Bed Days or Total Patient Days)	2,957
*Minimum Utilization Adjustment	
Laundry	\$ 5,000
Housekeeping	\$ 8,000
Plant Operations	\$ 46,000
Administration	\$165,000
Total Expense	\$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	\$ 4,323
Patient Care	\$400,000
Ancillary	\$ 10,000
Dietary	\$ 25,000
Laundry	\$ 5,000
Housekeeping	\$ 8,000
Plant Operations	\$ 46,000



Administration	<u>\$165,000</u>
Total Routine Service Cost	\$659,000
Less: Minimum Utilization Adjustment*	<u>(\$ 4,323)</u>
Routine Service Cost, Adjusted for Minimum Utilization	\$654,677
SFY 2018 Trend	3.025%
SFY 2019 Trend	<u>2.65%</u>
Trended Routine Service Cost	\$692,355
Total Patient Days	<u>2,900</u>
Routine Service Cost Per Diem	\$ 238.74

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2019 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

I. The following is an illustration of how the ICF/IID FRA assessment is calculated:

SFY 2019 ICF/IID FRA Assessment	\$40,000
Total Patient Days	<u>2,900</u>
ICF/IID FRA Per Diem	\$ 13.79

(c) Return on Equity. An owner's net equity consists of investment capital and working capital as indicated in subsection (6)(S). Each ICF/IID's Return on Equity per diem is calculated as follows:

I. Investment Capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principal, and equipment purchase less the accumulated depreciation).

II. Working Capital. Working capital represents the amount of capital which is required to ensure proper operation of the facility and shall be calculated as 1.1 months of the total expenses less depreciation.

III. The total net equity shall be multiplied by the rate of return as set forth in subsection (6)(S) to determine the return on equity. The return on equity is subject to the minimum occupancy percent of ninety percent (90%) in determining the per diem.

IV. The following is an illustration of how this subpart (4)(B)1.A.(III)(c) is calculated:

Investment Capital			
	<u>Equipment</u>	<u>Building</u>	<u>Total</u>
Cost	\$130,000	\$300,000	\$430,000
Less: Prior Years Depreciation	(\$120,000)	(\$225,000)	(\$345,000)
Less: Current Year Depreciation	<u>(\$2,400)</u>	<u>(\$8,500)</u>	<u>(\$10,900)</u>
Total Investment Capital	\$7,600	\$66,500	\$74,100
Working Capital			
Total Expenses			\$659,000
Less: Current Year Depreciation Expense			<u>(\$10,900)</u>
			\$648,100
Divided by 12 Months			<u>12</u>
			\$ 54,008
Times 1.1 Months			<u>1.1</u>
Total Working Capital			<u>\$ 59,409</u>
Net Equity (Investment Capital + Working Capital)			\$133,509
Rate of Return			<u>5.125%</u>
Return on Equity			\$ 6,842

Minimum Utilization Days	<u>2,957</u>
Return on Equity Per Diem	\$ 2.31

(c) Rebased Per Diem Rate. The total calculated per diem is the sum of the Routine Service Cost per diem, the ICF/IID FRA per diem and the Return on Equity per diem. To determine the rebased per diem rate, the total calculated per diem is compared to the current per diem rate and the facility will be held harmless if the total calculated per diem is less than the current per diem rate (i.e., if the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem).

Routine Service Cost per diem	\$238.74
ICF/IID FRA per diem	\$ 13.79
Return on Equity per diem	<u>\$ 2.31</u>
Total Calculated Per Diem	\$254.84

Current Per Diem Rate	\$200.00
-----------------------	----------

Rebased Per Diem Rate \$254.84
(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

B. Effective for dates of service beginning October 1, 2022, each nonstate-operated ICF/IID shall have its prospective rate recalculated based on its 2020/2021 fiscal year-end cost report using the same principles and methodology as detailed throughout sections (1)-(13) of this regulation and as set forth in subparagraph (4)(B)1.A.

(I) The nonstate-operated ICF/IID shall have its prospective rate recalculated based on their 2021 fiscal year-end cost report unless they do not have a full twelve- (12-) month 2021 fiscal year end cost report in which case the 2020 fiscal year-end cost report shall be used to calculate the prospective rate.

(II) The costs from the 2020 and 2021 fiscal year-end cost reports shall be trended using the indices from the most recent publication of the *Healthcare Cost Review* available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four- (4-) quarter moving average. 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 2023, the trends are as follows:

- (a) 2021=2.825%
- (b) 2022=2.500%
- (c) 2023=3.3800%

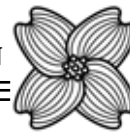
(III) The current year depreciation will not be deducted from the working capital to determine Return on Equity.

2. Interim Rate Calculation.

A. In the case of a newly certified facility where a valid Title XIX participation agreement has been executed, a request for an interim rate must be submitted in writing to the MO HealthNet Division.

(I) The interim rate shall be determined based on the projected estimated operating costs. The facility's request must specifically and clearly identify the interim rate and be supported by complete and accurate documentation satisfactory to the single state agency. Documentation submitted must include a budget of the projected estimated operating costs. Other documentation may also be required to be submitted upon the request of the division.

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost



report) prepared in accordance with the principles of this rule. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7) of this rule.

(III) Prior to establishment of a prospective rate for newly certified facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services or authorized representative to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this rule.

(IV) The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and a prospective reimbursement rate shall be determined on the allowable per diem cost as set forth in section (4) of this rule. The prospective reimbursement rate shall be effective on the first day of the facility's rate setting cost report and payment adjustments shall be made for claims paid at the interim rate.

3. 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. Extraordinary circumstances. A participating facility that has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request should be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request should clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment should be supported by complete and accurate documentation 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:

(I) 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 or ICF/IID industry in general, and the circumstances have a

substantial cost effect; and

(II) Extraordinary circumstances, which are beyond the reasonable control of the ICF/IID and are not a product or result of the negligence or malfeasance of the ICF/IID, include –

(a) Unavoidable acts of nature are natural wildfire, earthquakes, hurricane, tornado, lightning, flooding, or other natural disasters for which no one can be held responsible, that are not covered by insurance and that occur in a federally declared disaster area; or

(b) Vandalism, civil disorder, or both that are not covered by insurance; or

(c) 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;

C. When an adjustment is based on an Administrative Hearing Commission or court decision;

D. New, expanded, or terminated services may be subject to rate review;

E. Disallowance of federal financial participation; and

F. The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in 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 the ICF/IID must provide, 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, incontinency care, tray service, and enemas;

2. Items that 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; facilities must provide all 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, nondepreciable 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 that the facility furnishes 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 (8) 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. The provider shall specifically provide for temporary leave of absence days 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) Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the owner actually performs the services and the services are necessary.

2. "Compensation" means the total benefit to the owner, within the limitations set forth in this rule, of the services s/he renders to the facility. Compensation includes direct payments to the owner 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 that 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. MO HealthNet auditors may determine the reasonableness of compensation 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 that 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 ownership, 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 MO HealthNet Division will allow the basis of donated assets to the extent of the recognized 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" means 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 the 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 (6)(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 the 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 that 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 (6)(C) of this rule, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection (6)(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 if 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 that 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 that 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 that 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 that 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. The MO HealthNet Division considers costs for wardrobe and similar items likewise nonallowable.

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance that the MO HealthNet Division does not consider 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. The MO HealthNet Division considers this type of insurance 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. Facilities shall exclude interest income from funded pensions or retirement plans 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. 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 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 that 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. The provider shall amortize organizational costs 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.

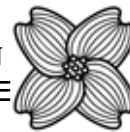
5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational 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 limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs that 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 providing utilization review on behalf of a Title XIX participant. The provider shall apportion utilization review costs incurred for Title XVIII and Title XIX based on 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 provider will calculate the following cost centers as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may the provider carry forward costs disallowed under this provision 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 by the provider to, in a readily ascertainable manner, separately account for any of the revenues specifically set out previously in this rule, shall result in the provider's termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs if interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in subsection (6)(R) 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 the provider shall only use

for a specific purpose designated by the donor. Those restricted funds that 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 re-restrict restricted funds designated by the donor for paying operating costs, the provider will not offset the funds from the 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 a donor gives to a provider without restriction as to their use. The provider can use these funds in any manner. However, those unrestricted funds that are not transferred funds and that the provider uses to pay 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. The MO HealthNet Division does not consider these funds a grant or gift for reimbursement purposes, so have no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. Providers shall apportion their allowable cost areas between MO HealthNet program participant residents and other residents so that the share of allowable cost areas borne by the MO HealthNet program is based upon actual services received by MO HealthNet program participants.

2. To accomplish this apportionment, providers shall apply the ratio of patient days for MO HealthNet participants to the total patient days.

3. 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.

4. 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. The provider shall maintain a census log 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.

5. 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.

6. In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons 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 be



calculated using the nursing home allowable percentage as defined in 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services.

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 that is required to ensure proper operation of the facility.

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

5. The provider shall apportion its return on the owner's net equity to the MO HealthNet program based on 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.

(T) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The fee assessed to ICF/IIDs in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(7) 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. The provider shall submit an annual cost report for the fiscal year to the department on forms to be furnished by the department for that purpose. Each provider shall submit the completed cost report by the first day of the sixth month following the close of the fiscal period.

2. Unless the provider has previously filed adequate and current documentation in the following areas with the department, authenticated copies of the following documents must be submitted by the provider 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. The facility shall maintain adequate documentation for all line items on the uniform cost reports and must submit the document to the department upon request.

4. If a cost report is more than ten (10) days past due, payment may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this regulation, the department will release the withheld payments 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 may withhold all remaining payments from the selling provider until the provider files the cost report. 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, the department will release any withheld payment to the selling provider.

(B) Certification of Cost Reports.

1. The facility must certify the accuracy and validity of any cost report. 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 available in section (8) of this rule.

2. The provider shall retain all records associated with the preparation and documentation of the data associated with the cost report for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The provider shall base the submitted cost report on the accrual basis of accounting.

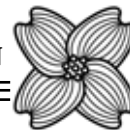
2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided the governmental institution treats capital expenditures appropriately.

(E) Audits.

1. The provider shall base cost reports upon the provider's financial and statistical records that 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 or authorized agent will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever their personnel notes a cost variance or exception.

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 accept unqualified opinions only if they are 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.

(8) Sanctions and Overpayments.

(A) The department may impose sanctions 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.

(9) 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 prior authorized 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 that provide prior authorized 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 section (4) of this rule.

(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 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. The provider will maintain documentation to effectively monitor and evaluate experience during administration of this rule.

APPENDIX A

Routine Covered Medical Supplies and Services

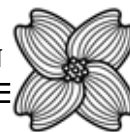
ABD Pads
A & D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses
Air P.R. Mattresses
Airway Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Antacids, Nonlegend
Applicators, Cotton-Tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto 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, 208.201, and 660.017, 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 amendment 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. Emergency amendment filed Oct. 25, 2019, effective Nov. 8, 2019, expired May 5, 2020. Amended: Filed Oct. 25, 2019, effective May 30, 2020. Emergency amendment filed March 16, 2023, effective March 30, 2023, expired Sept. 25, 2023. Amended: Filed March 16, 2023, effective Oct. 30, 2023.

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; and 660.017, RSMo 1993, amended 1995.*

13 CSR 70-10.040 Medicaid Eligibility and Preadmission Screening for Mentally Ill and Intellectually Disabled Individuals

PURPOSE: *This rule outlines the preadmission screening requirements related to eligibility for Title XIX.*

PUBLISHER'S NOTE: *The secretary of state has determined that publication of the entire text of the material that 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) Any individual who is admitted to a Medicaid certified nursing facility (NF) bed on or after January 1, 1989, and has not been screened for mental illness (MI), intellectual disability (ID), or related condition (RC) prior to admission or who does not have a valid special admission category will not be eligible for Title XIX payments to be made on his/her behalf for NF services.

(A) The facility must complete a preadmission screening for individuals with a mental illness and individuals with ID as described in 42 Code of Federal Regulations (CFR) 483.20(k).

(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).

(C) For purposes of this rule an individual is considered to have an ID if the individual is intellectually disabled as defined in 42 CFR 483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010.

(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 (PASRR) will include an assessment of the individual's –

(A) Physical condition;

(B) Mental condition;

(C) Need for nursing facility services to comply with 42 CFR 483.112(a); and

(D) Need for specialized services for MI, ID, or RC.

1. If a Medicaid nursing facility resident is determined to need specialized services, the state will provide or arrange for such services while the Medicaid participant is in a nursing facility.

(4) For purposes of this rule, the term “specialized services” is defined for individuals with –

(A) MI as the continuous and aggressive implementation of an individualized plan of care developed and supervised by an interdisciplinary team, which includes a physician, qualified mental health professional and, as appropriate, other professional that prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of MI that necessitates supervision by trained mental health personnel and is directed toward diagnosing and reducing the resident's behavioral symptoms that necessitated institutionalization, improving his or her level of independent functioning, and achieving a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time; and

(B) ID or other RC(s) as a continuous program for each client that results in treatment that meets the requirements of 42 CFR 483.440(a)(1) and 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 has 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 suspected of having a MI, ID, or RC.

(B) The purpose of a Level II evaluation is to perform a



comprehensive evaluation in person or by telehealth to validate the applicant has a MI, ID, or RC and evaluate the individual's treatment needs to determine if NF services are needed and if specialized services are required. 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 unless the resident meets the requirements of 42 CFR 483.118(c)(1) and elects to stay in the NF.

1. For those individuals already residing or admitted to a NF who experience a change of condition or for those individuals who fall under a special admission category specified in subsection (7)(D), a resident review of the individual's records in accordance with 42 CFR 483.134 and 483.136 may be required to determine if specialized services are appropriate or if modifications are needed.

(7) Any individual identified as having a suspected MI, ID, or RC by the Level I screening will be referred to Department of Mental Health (DMH) for a Level II evaluation. A Level II evaluation is required prior to admittance into a certified bed located in an NF, unless a valid special admission category, as specified in subsection (7)(D), applies.

(A) DMH or its designee will perform all Level II evaluations. If a review indicates a level of services that can only be furnished in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), 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 level of care under 19 CSR 30-81.030 needed for authorization of Medicaid nursing facility payments.

(B) Any individual determined through the Level II evaluation to require specialized services and to not require NF services shall be discharged if the Level II evaluation determines that the individual's nursing care needs can be met in other settings regardless of the level of care under 19 CSR 30-81.030 unless the resident meets the requirements of 42 CFR 483.118(c)(1) and elects to stay in the NF.

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 evaluation and communicated to the NF by the Department of Health and Senior Services (DHSS), 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 unless the resident meets the requirements of 42 CFR 483.118(c)(1) and elects to stay in the NF.

2. A written evaluation report must be prepared at the conclusion of each Level II evaluation. The evaluation report must identify the specific nursing facility services, intellectual disability services, or mental health services required to meet the evaluated individual's needs.

3. Notice of a decision resulting from a Level II evaluation shall be sent to the referring entity who submitted the Level I screening forms and the proposed placement facility, if different, as well as the evaluated individual and his or her legal representative, the individual's attending physician, and the discharging hospital unless the hospital discharge is exempt from the preadmission screening per 42 CFR 483.106(b)(2).

(C) Any individual admitted to or currently residing in an NF and identified as having a suspected MI, ID, or RC by the Level I screening shall be subject to a Level II evaluation.

(D) Special admission categories are subject to advanced

group determinations as defined in 42 CFR 483.130(b)(1) and are based on the criteria specified in 42 CFR 483.130(c).

1. The following special admission categories may be admitted directly to an NF after the Level I screening is completed and receive the Level II evaluation or resident review following admission as appropriate based on the individual's medical condition or admission justification:

A. Terminal illness. As defined by the Social Security Act, an individual is terminally ill if there is a medical prognosis that the individual's life expectancy is six (6) months or less;

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 that results in a level of physical impairment so severe the individual could not be expected to benefit from specialized services;

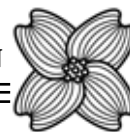
C. Emergency provisional admission. This category is for a situation in which an individual needs placement to protect the individual from serious physical harm to self or others. The NF must contact DHSS Adult Abuse and Neglect Hotline to make a formal request prior to admission. This special admission category requires prior authorization by DHSS as an emergency. No more than seven (7) days will be allowed for an emergency admission. The Department of Social Services, Family Support Division (FSD), will manage those dates based on information from DHSS. If the individual needs to stay in the NF longer than seven (7) days, the NF must immediately notify DHSS to determine continued stay. A comprehensive Level II evaluation or resident review must be performed after the initial seven- (7-) day period if continued stay is necessary;

D. Respite care. An individual may be admitted and remain in an NF 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 comprehensive Level II evaluation is not required for the first thirty (30) consecutive days. FSD will control the NF authorized payment dates by means of a form they send to DHSS. No payment will be made to the NF beyond the thirty (30) days. If a situation arises in which the stay is longer than thirty (30) days, the NF must contact DHSS. If a continued stay is authorized, a comprehensive Level II evaluation or resident review must be performed within forty (40) calendar days of the individual's admission to the NF if continued stay is necessary; and

E. Direct transfer from a hospital. If a physician attests that the individual is likely to need thirty (30) days or less of NF care for the condition for which the individual was hospitalized, the individual may be admitted to an NF and no Level II evaluation or resident review is required during that thirty (30) days or less period. NF payment will be made for no more than thirty (30) days. If after admission to the NF it becomes apparent that the individual will need NF care longer than thirty (30) days, the NF must immediately notify DHSS. If a continued stay is approved, a comprehensive Level II evaluation must be performed within forty (40) calendar days of the individual's admission to the NF.

(8) The Department of Social Services, DHSS, and DMH will have joint responsibility for the preadmission screening process.

(9) This rule incorporates by reference the following materials, as published by U.S. Government Publishing Office, U.S. Superintendent of Documents, Washington, DC 20402, October 1, 2023. This rule does not incorporate any subsequent amendments or additions:



- (A) 42 CFR section 483.20(k);
- (B) 42 CFR section 483.102(b)(1);
- (C) 42 CFR section 483.102(b)(3);
- (D) 42 CFR section 435.1010;
- (E) 42 CFR section 483.112(a);
- (F) 42 CFR section 483.440(a)(1);
- (G) 42 CFR section 483.118(c)(1);
- (H) 42 CFR section 483.134;
- (I) 42 CFR section 483.136;
- (J) 42 CFR section 483.106(b)(2);
- (K) 42 CFR section 483.130(b)(1); and
- (L) 42 CFR section 483.130(c).

AUTHORITY: section 208.201, RSMo 2016, and section 208.153, RSMo Supp. 2025. 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. Amended: Filed Nov. 14, 2025, effective May 30, 2026.*

**Original authority: 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024, and 208.201, RSMo 1987, amended 2007.*

13 CSR 70-10.050 Pediatric Nursing Care Plan (Rescinded August 30, 2018)

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. Rescinded: Filed Jan. 16, 2018, effective Aug. 30, 2018.

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 (WMACPDPSOF) and the FY-89 WMACPDPSOF annualized by dividing by two (2).

Example

FY-87 WMACPDPSOF \$128.06
 FY-89 WMACPDPSOF \$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 WMACPDPSOF and the second prior year WMACPDPSOF 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 WMACPDPSOF \$160
 FY-90 WMACPDPSOF \$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 administration 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.

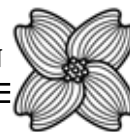
(K) Utilization Review. Incurred cost for the performance of required utilization review for ICF/MR is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of Title XIX participants. Utilization review costs incurred for Title XVIII and XIX must be 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.

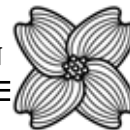
(14) Transition. Cost reports used for the determination of the rates and the historical rate of change shall be adjusted by the division in accordance with the cost principles provided in this plan.

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, 2012; 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 (3) 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 participant 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 percent (97.00%), rounded to four (4) decimal places (i.e., 0.9700 or 97.00%), of Medicaid certified beds for the quarter prior to the quarter during which hospital leave is taken. The occupancy rate is based on the data from the Certificate of Need (CON) Quarterly Survey from the Department of Health and Senior Services. The quarters referenced herein are calendar year quarters (i.e., January – March, April – June, July – September, and October – December);

(D) The Medicaid participant 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 participant 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 have been received by the MO HealthNet Division 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 participant shall be ineligible for reimbursement to nursing facilities for two otherwise available temporary leave of absence days as described in 13 CSR 70-10.015(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 70-10.015(5)(D).

AUTHORITY: sections 208.153, 208.159, 208.201, and 660.017, RSMo 2016.* 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. Amended: Filed Aug. 28, 2018, effective April 30, 2019.

*Original authority: 208.153, RSMo 1967, amended 1973, 1989, 1990, 1991; 208.159, RSMo 1979; 208.201, RSMo 1987; and 660.017, RSMo 1993, amended 1995.

**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.

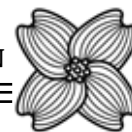
(K) A facility with certified and noncertified beds shall allocate allowable costs related to the provision of HIV nursing facility services on the cost report, in accordance with the cost report instructions. The methods for allocation must be supported by adequate accounting and/or statistical data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

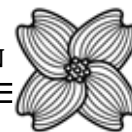
(FF) Interim rate. The interim rate shall be based upon the budgeted cost report (version MSIR-1 (3-95)) that has been submitted to the division. The interim rate shall be the sum of one hundred percent (100%) of the budgeted patient care costs, ninety percent (90%) of the budgeted ancillary costs and 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, 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.

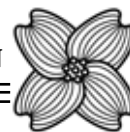
1. Property insurance. Insurance cost on property of the HIV nursing facility used to provide HIV nursing facility services. Property insurance should be reported on line 107 of the cost report version MSIR-1 (3-95).

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 nonproprietary 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 nonworking 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 Howerton 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 postmarked 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.

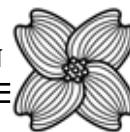
2. If the director of the Institutional Reimbursement Unit does not receive, in writing, notification of a change of control or ownership and a cost report ending with the date of the change of control or ownership, upon learning of a change of control or ownership, thirty thousand dollars (\$30,000) 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	\$20.00
Total Per Diem	\$57.00
divided by 12 months	12
	\$ 4.75
Times 1.1 months	1.1
	\$ 5.23
Times Prime + 2%	
(Chase Manhattan plus 2%)	11%
Working Capital Allowance per day	\$.58

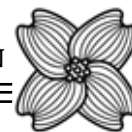
(F) The following is an illustration of how subsections (11)(A), (11)(B), (11)(C), (11)(D), and (11)(E) determine the per diem rate:

	Allowable	Cost Ceiling	Per Diem
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			\$.58
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 adjustments 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, 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.

(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%.

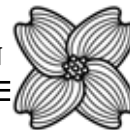
- C. The medians and ceilings shall be recalculated each year, based upon the trended costs included in the new databank that is developed each year.

- 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

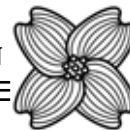
Baby powder
 Bedside tissues
 Bibs, all types
 Deodorants
 Disposable underpads of all types
 Gowns, hospital
 Hair care, basic including washing, cuts, sets, brushes, combs, nonlegend shampoo
 Lotion, soap, and oil
 Oral hygiene including denture care, cups, cleaner, mouthwashes, toothbrushes, and toothpaste
 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 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, 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

IV. 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 publication of the entire text of the material that 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. If the facility is also participating in the Title XVIII Medicare (Medicare) program, the Medicaid cost report period shall be the same as the Medicare cost report period. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

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, "Missouri Department of Health and Senior Services, Certificate of Need Quarterly Survey," 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 and is available at <https://consurvey.dhss.mo.gov/CONFacility/Login.aspx>, June 23, 2025. 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 is not open for the entire quarter relative to the applicable quarterly survey, as set forth in section (2), and the applicable quarterly survey does not represent a full quarter's worth of days 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 (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 submit the applicable quarterly survey, the annualized level of patient occupancy days used to determine the NFRA shall be the greater of –

(a) The facility's current NFRA assessment (i.e., the NFRA assessment that is in effect prior to the new SFY update for which the facility did not submit a survey); or

(b) Eighty percent (80%) of licensed bed days.

(III) If a nursing facility has intermediate care facility (ICF) licensed beds and skilled nursing facility (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) 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.

(D) 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 and 621.055, RSMo.

(2) NFRA Rates. The amount of the fees imposed under this rule shall not exceed the percentage of net patient service revenues permitted by federal regulation pursuant to 42 CFR 433.68 as determined by the department on a per occupied bed per day basis. Federal regulation 42 CFR 433.68 specifies that permissible health care related taxes shall produce revenues that are less than or equal to six percent (6%) of the revenues received by the health care provider. Federal regulation 42 CFR 433.68 is incorporated by reference as published by Office of the Federal Register, National Archives and Records Administration, 732 N. Capitol Street NW, Washington, DC 20401, October 1, 2024. This rule does not incorporate any subsequent amendments or additions. The NFRA rates determined by the division 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);

(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); and

(Q) Effective July 1, 2018, the NFRA will be twelve dollars and ninety-three cents (\$12.93) 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:

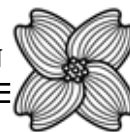
1. The facility's new, decreased licensed bed capacity shall be multiplied by three hundred sixty-five (365) days to determine the annualized level of patient occupancy days;

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; and

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, 198.421, 198.424, 198.427, 198.431, 198.433, 198.436, 208.159, and 208.201, RSMo 2016, and sections 198.439 and 208.153, RSMo Supp. 2025. 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. Emergency amendment filed May 9, 2019, effective June 1, 2019, expired Dec. 30, 2019. Amended: Filed May 9, 2019, effective Dec. 30, 2019. Emergency amendment filed June 23, 2025, effective July 8, 2025, expired Feb. 26, 2026. Amended: Filed Aug. 12, 2025, effective March 30, 2026.

**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, amended 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, 2016, 2018, 2019, 2020, 2021, 2024; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012, 2024; 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) Definitions.

(A) “Nurse assistant training agency” is an agency which is approved by the Department of Health and Senior Services under 19 CSR 30-84.010(7).

(B) “Basic course” is 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” means taking the final examination of the basic course without taking the entire basic course.

(D) “Cost report” is the Financial and Statistical Report for Nursing Facilities, required attachments, and all worksheets supplied by the division for this purpose per 13 CSR 70-10.015, effective January 1, 1995, through June 30, 2022, and 13 CSR 70-10.020, effective beginning July 1, 2022. The cost report details 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 and Senior Services” is the

department responsible for the survey, certification, and licensure as prescribed in Chapter 198, RSMo.

(F) “Desk audit” is the MO HealthNet Division or its authorized agent’s audit of a provider’s cost report without a field audit.

(G) “Division,” unless otherwise specified, refers to the Department of Social Services, MO HealthNet Division that is charged with administration of MO HealthNet (Medicaid) Program.

(H) “Facility fiscal year” is a facility’s twelve- (12-) month fiscal reporting period.

(I) “Field audit” is an on-site audit of the nursing facility’s records performed by the department or its authorized agent.

(J) “Nursing facility (NF)” is, 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.

(K) “Occupancy rate” is 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.

(L) “Patient day” is 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), effective January 1, 1995, through June 30, 2022, and 13 CSR 70-10.020(5)(C), effective beginning July 1, 2022, 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.

(M) “Provider or facility” is 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 participants.

(2) General Principles.

(A) Provisions of this reimbursement plan shall apply only to nursing facilities with valid provider agreements certified by the Department of Social Services, Missouri Medicaid Audit and Compliance (MMAC) for participation in the MO HealthNet (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 Department of Health and Senior Services will approve or disapprove nurse assistant training programs in the state of Missouri. If the Department of Health and Senior Services withdraws approval of a formerly approved nurse assistant training program, the facility may continue to teach (and bill MO HealthNet 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 Department of Health and Senior Services. 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 Department of Health and Senior Services.

(D) Training Agencies – Any nurse assistant training agency must be approved by the Department of Health and Senior Services per 19 CSR 30-84.010(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 19 CSR 30-84.010 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 non-allowable 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 – Nursing facilities with valid provider agreements may bill the MO HealthNet Division 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 19 CSR 30-84.010(9) and must have a signed agreement with the Department of Health and Senior Services. 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.

(3) 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 Department of Health and Senior Services 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. One thousand five hundred dollars (\$1,500) 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, as follows:

Classroom Training	\$600
On-the-Job Training	\$575
Textbook and Supplies	\$200
Written Test	\$30
Skills Test	\$95
Total Allowable to be Prorated on Medicaid Utilization	\$1,500

2. A percentage of the one thousand five hundred dollars (\$1,500) 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 \$1,500 allowable would be –

Classroom Training (\$600 x 18.75 hours/75 hours)	\$150
On-the-Job Training	\$0
Textbook and Supplies	\$200
Written Test	\$30
Skills Test	\$95
Total Allowable to be Prorated on Medicaid Utilization	\$475

3. One hundred twenty-five dollars (\$125) 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.

(4) 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 Department of Health and Senior Services 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 reimbursement to the division on the approved billing form;

(F) The division will prorate costs based on Medicaid utilization as follows:

1. One thousand five hundred dollars (\$1,500) 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 one thousand five hundred dollars (\$1,500) 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 (3)(C)2. of this regulation; and

3. One hundred twenty-five dollars (\$125) for nurse assistants who do not complete any lesson plans through a challenge process and pass the final exam; and

(G) The MO HealthNet Division 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 208.153, 208.159, 208.201, and 660.017, RSMo 2016, and section 208.152, RSMo Supp. 2023.* Original rule filed May 30, 1995, effective Dec. 30, 1995. Amended: Filed Feb. 15, 1996, effective Sept. 30, 1996. Amended: Filed Aug. 8, 2018, effective March 30, 2019. Emergency amendment filed Feb. 26, 2024, effective March 11, 2024, expired Sept. 6, 2024. Amended: Filed Feb. 26, 2024, effective Aug. 30, 2024.

*Original authority: 208.152, RSMo 1967, amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993, 2004, 2005, 2007, 2011, 2013, 2014, 2015, 2016, 2018, 2021, 2023; 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991, 2007, 2012; 208.159, RSMo 1979; 208.201, RSMo 1987, amended 2007; 660.017, RSMo 1993, amended 1995.

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 11, Section 11.445. 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 1126-1128).

13 CSR 70-10.160 Public Nursing Facility Upper Payment Limit Payments

PURPOSE: This rule implements a supplemental payment program for qualifying public nursing facilities.

(1) Effective for dates of service beginning July 1, 2013, Nursing Facility Upper Payment Limit (UPL) payments shall be made as set forth below in subsections (1)(A)-(1)(C). Maximum aggregate payments to all qualifying nursing facilities shall not exceed the UPL defined in 42 CFR 447.272 in each state fiscal year.

(A) An annual UPL payment shall be made after 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.

1. A public nursing facility is defined as being owned or operated by a public entity.

(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: sections 208.201 and 660.017, RSMo 2016.* 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. Amended: Filed Aug. 28, 2018, effective April 30, 2019.

*Original authority: 208.201, RSMo 1987, amended 2007 and 660.017, RSMo 1993, amended 1995.