Rules of
Department of Social Services
Division 70—Division of Medical Services
Chapter 10—Nursing Home Program

Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—Division of Medical Services
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, handfeeding, incontinency care, tray services and enemas;

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

C. Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually in small quantities such as alcohol, applicators, cotton balls, and bandaids, antacids, aspirins (and other nonlegend 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 rerestrict 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.