DEPARTMENT OF HEAL1H & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 52-26-12
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations (CMSO)

MAR 22 2010

Dr. Robert L. Robinson
Executive Director
State of Mississippi
Office of the Governor
Division of Medicaid
Walter Sillers Building, Suite 1000
550 High Street
Jackson, MS 39201

RE: SPA MS 09-004

Dear Dr. Robinson:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 09-004. Effective February 8, 2010 this amendment modifies the State's reimbursement methodology for setting payment rates for nursing facility services. Specifically, the amendment updates the cost center percentages used to calculate the weighted trend factors for the annual rate increases and deletes obsolete language.

We conducted our review of your submittal according to the statutory requirements at sections 1902(aX13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR Part 447. We have found that the proposed changes in payment methodology comply with applicable requirements and therefore have approved them with an effective date of February 8, 2010. We are enclosing the CMS-179 and the amended approved plan pages.

If you have any questions, please call Stanley Fields at (502) 223-5332 or Venesa Day at 410-786-8281.

Sincerely

//s//

Cindy Mann
Director, CMSO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **2009-004**

2. STATE: **MS**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: **December 21, 2009**

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.160; 42 CFR 441, Subpart D: 42 CFR 447, subparts B and C; and 42 CFR 483, subparts B, D, F, and I.

7. FEDERAL BUDGET IMPACT:
a. FFY **2010** < **$100,000**
b. FFY **2011** < **$100,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D (Page 1 thru 176)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D (Page 1 thru 174)

10. SUBJECT OF AMENDMENT:
This SPA is being filed to remove reference to outdated language, such as reference to Review Board, that no longer exists, to revise the trend factor example to reflect updates caused by federal changes to the Consumer price indices, to remove wording on incontinence supplies as mandated by CMS representatives, to remove reference to cost report software that was abandoned, etc.

11. GOVERNOR'S REVIEW *(Check One)*:
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
//s//

13. TYPED NAME:
Robert L. Robinson

14. TITLE: Executive Director

15. DATE SUBMITTED: 12-21-09

16. RETURN TO:
Robert L. Robinson
Mississippi Division of Medicaid
Attn: Ginnie McCardle
550 High Street, Suite 1000
Jackson, MS 39201-1399

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
12-21-09

18. DATE APPROVED: 03-22-10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
02-08-10

20. SIGNATURE OF REGIONAL OFFICIAL:
//s//

21. TYPED NAME:
Cindy Mann

22. TITLE: Director, CMSO

23. REMARKS:

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE RECIPIENTS

OF

LONG TERM CARE FACILITIES

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Introduction

This plan is for use by providers, their accountants, the Division of Medicaid, and its fiscal agent in determining the allowable and reasonable costs of and corresponding reimbursement for long-term care services furnished to Medicaid recipients. The plan contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Division of Medicaid. These procedures will be used in determining the payment to the provider of its allowable and reasonable costs. The payment to nursing facility providers only will be under a case-mix reimbursement system.

The program herein adopted is in accordance with Federal Statute, 42 U.S.C.A., section 1396a(A)(13) and (28). The applicable Federal Regulations are 42 CFR 440.160; 42 CFR 441, Subpart D; 42 CFR 447, subparts B and C; and 42 CFR 483, subparts B, D, F, and I. Each long-term care facility that has contractually agreed to participate in the Title XIX Medical Assistance Program will adopt the procedures set forth in this plan; each must file the required cost reports and will be paid

for the services rendered on a rate related to the allowable and reasonable costs incurred for care and services provided to Medicaid recipients. Payments for services will be on a prospective basis.

In adopting these regulations, it is the intention of the Division of Medicaid to pay the allowable and reasonable costs of covered services and establish a trend factor to cover projected cost increases for all long-term care providers. For nursing facility providers only, the Division of Medicaid will include an adjustable component in the rate to cover the cost of service for the facility specific case-mix of residents as classified under the Multi-State Medicare Medicaid Payment Index (M^3PI). While it is recognized that some providers will incur costs in excess of the reimbursement rate, the objective of this plan is to reimburse providers at a rate that is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program.

As changes to this plan are made, the plan document will be updated on the Medicaid website.

Questions related to this reimbursement plan or to the interpretation of any of the provisions included herein should be addressed to:

Office of the Governor
Division of Medicaid
Suite 1000, Walter Sillers Building
550 High Street
Jackson, Mississippi 39201

1-3 Cost Reporting

A. Reporting Period

All Nursing Facilities, PRTF's, and ICF-MR's shall file cost reports based on a standard year end as prescribed by the provisions of this plan. State owned facilities shall file cost reports based on a June 30 year end. County owned facilities shall file cost reports based on a September 30 year end. All other facilities shall use a standard year end of December 31. Standard year end cost reports should be filed from the date of the last report. Facilities may request to change to a facility specific cost report year end, if the requested year end is the facility's Medicare or corporate year end.

Other provisions of this plan may require facilities to file a cost report for a period other than their standard reporting year. Facilities which previously filed a short period cost report that includes a portion of their standard reporting year must file a cost report for the remainder of their standard reporting year, excluding the short period for which a report was previously required. For example, a facility that has a standard reporting year of January 1 through December 31 and undergoes a change of classification on April 1, would be required to file the following cost reports:

1. a cost report for the period January 1 through March 31;
2. a short-period cost report would be required per Section 1-3, Q, for the period April 1 through June 30; and
3. a regular year-end cost report for the period July 1 through December 31.

B. When to File

Each facility must submit a completed cost report on or before the last day of the fifth month following the close of the reporting period. Should the due date fall on a weekend, a State of Mississippi holiday or a federal holiday, the due date shall be the first business day following such weekend or holiday.

C. Extension for Filing

Extensions of time to file may be granted due to unusual situations or to match a Medicare filing extension for a provider-based facility. The extensions may only be granted by the Director of the Division of Medicaid.

D. Delinquent Cost Reports

Cost reports that are submitted after the due date will be assessed a penalty in the amount of $50.00 per day the cost report is delinquent. This penalty may only be waived by the Director of the Division of Medicaid.

E. What to Submit

All cost reports must be filed in electronic format, with the following:

(1) Working Trial Balance, facility and home office (if applicable);

(2) Depreciation Schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted. If the facility has home office costs, copies of the home office depreciation schedule must also be submitted;

(3) Any work papers used to compute adjustments made in the cost report;

(4) Narrative description of purchased management services or a copy of contracts for managed services, if applicable;

(5) Form 2 with an original signature on the Certification by Officer or Administrator of Provider. Scanned signatures are acceptable.

When it is determined that a cost report has been submitted that is not complete enough to perform a desk review, the provider will be notified. The provider must submit a complete cost report. If the request is made and the completed cost report is not received on or before the due date of the cost report, the provider will be subject to the penalties for filing delinquent cost reports. When it is determined that the cost report submitted is complete but is missing certain information, providers will be allowed a specified amount of time to submit the requested information without incurring the penalty for a delinquent cost report. For cost reports which are submitted by the due date, ten (10) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit

the additional information. For cost reports which are submitted after the due date, five (5) working days from the date of the provider's receipt of the request for additional information will be allowed for the provider to submit the additional information. If requested additional information has not been submitted by the specified date, an additional request for the information will be made. An exception exists in the event that the due date comes after the specified number of days for submission of the requested information. In these cases, the provider will be allowed to submit the additional requested information on or before the due date of the cost report. Information that is requested that is not submitted following either the first or the second request may not be submitted for reimbursement purposes. Providers will not be allowed to submit the information at a later date, at the time of audit, the cost report may not be amended in order to submit the additional information, and an appeal of the disallowance of the costs associated with the requested information may not be made. Adjustments may be made to the cost report by the Division of Medicaid to disallow expenses for which required documentation, including revenue cost findings, is omitted.

F. Where to File

The cost report and related information should be mailed to:

Office of the Governor
Division of Medicaid
Reimbursement Division
Suite 1000, Walter Sillers Building
550 High Street
Jackson, MS 39201

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

are adopted by the Division of Medicaid.

H. Amended Cost Reports

The Division of Medicaid accepts amended cost reports in electronic format for a period of twenty-four (24) months following the end of the reporting period. Amended cost reports should include Form 1, in order to explain the reason for the amendment in Section II; Form 2 with original signature; and all forms that are being amended. Each form and schedule submitted should be clearly marked "Amended" at the top of the page. Amended cost reports submitted after the annual base rate is determined will be used only to adjust the individual provider's rate. Cost reports may not be amended after an audit has been initiated.

I. Desk Reviews

The Division of Medicaid will conduct cost report reviews, as deemed necessary, prior to rate determination. The objective of the desk reviews is to evaluate the necessity and reasonableness of facility costs in order to determine the allowable costs used in the calculation of the prospective per diem rate.

Desk reviews will be performed using desk review programs developed by the Division of Medicaid. Providers will be notified, in writing, of all adjustments made to allowable costs.

Copies of desk review work papers will be furnished to the provider upon written request. Facilities have the right of appeal as described in Section 1-7 of this plan.

The desk review procedures will consist of the following:

1. Cost reports will be reviewed for completeness, accuracy, consistency and compliance with the Mississippi Medicaid State Plan and Division of Medicaid policy. All adjustments (whether in the provider's favor or not) will be made. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment and the amount of the adjustment, and the reference that is being used to justify the change (Ex. applicable section of the state plan).
2. Providers

may be requested to submit additional information prior to the completion of the desk review.

3. All desk review findings will be sent to the provider or its designated representative.
4. Desk reviews amended after the annual base rate is determined will be used only to adjust the individual provider's rate.

J. Audits of Financial Records

The Division of Medicaid will conduct on-site audits as necessary to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost report. Audit adjustments (whether in the provider's favor or not) will be made. All adjustments will include written descriptions of the line number on the cost report being adjusted, the reason for the adjustment, the amount of the adjustment, and the applicable section of the State Plan or CMS Pub. 15-1 that is being used to justify the change.

Audits issued after the annual base rate is determined will be used only to adjust the individual provider's rate.

K. Record Keeping Requirements

Providers must maintain adequate financial records and statistical data for proper determination of costs payable under the program. The cost report must be based on the financial and statistical records maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting. Financial and statistical data must be current, accurate and in sufficient detail to support costs contained in the cost report. This includes all ledgers, books, records and original evidence of cost (purchase requisitions for supplies, invoices, paid checks,

inventories, time cards, payrolls, basis for allocating costs, etc.) which pertain to the determination of reasonable costs. Statistical data should be maintained regarding census by payment source, room numbers of residents, hospital leave days and therapeutic leave days.

Financial and statistical records should be maintained in a consistent manner from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures, provided that full disclosure of significant changes are made to the Division of Medicaid. This disclosure should be made as a footnote on the cost report and should include the effect of the change.

All financial and statistical records, including cost reports, must be maintained for a period of three (3) years after submission to the Division of Medicaid. Records pertaining to open reviews or audits must also be maintained until the review or audit is finalized.

A provider must make available any or all financial and statistical records to the Division of Medicaid or its contract auditors for the purpose of determining compliance with the provisions of this plan or Medicaid policy.

For those cost reports selected for audit, all records which substantiate the information included in the cost report will be made

L. Failure to File a Cost Report

Providers that do not file a required cost report within six (6) months of the close of the reporting period will be subject to sanctions as described in Sanctions, Chapter 1 Section 7-C.

M. Change of Ownership

For purposes of this plan, a change of ownership of a facility includes, but is not limited to, inter vivos gifts, purchases, transfers, lease arrangements, cash and/or stock transactions or other comparable arrangements whenever the person or entity acquires a majority interest of the facility operations. The change of ownership must be an arm's length transaction consummated in the open market between non-related parties in a normal buyer - seller relationship.

Costs attributable to the negotiation or settlement of the sale or purchase of any capital asset whether by acquisition or merger for which any payment has previously been made shall not be considered reasonable in the provision of health care services and, therefore, shall not be included in allowable costs. These costs include, but are not limited to, legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies.

The seller must file a final cost report with the Division of Medicaid from the date of the last cost report to the effective date of the sale. The filing of a final cost report may be waived by the Division, if the cost report will not be needed for a trend factor calculation.

A facility which undergoes a change of ownership must notify the Division of Medicaid in writing of the effective date of the sale. The new owner must submit provider enrollment information required under Division of Medicaid policy.

For sales of assets finalized on or after July 1, 1993, there will be no recapture of depreciation.

N. Increase or Decrease in Number of Medicaid Certified Beds

Facilities which either increase or decrease the number of certified beds by less than one-third (1/3) the current number of certified beds will not be required to file a short-period cost report when the increase or decrease in the number of certified beds does not result in a change of facility classification. The per diem rate

after desk review. The rates computed based on the initial cost report of the facility will be effective beginning the same date the change of classification occurred.

1-4 Resident Fund Accounts

Nursing Facilities, ICF-MRs, and PRTFs must account for the facility's resident fund accounts in accordance with policies and procedures adopted by the Division of Medicaid. These policies and procedures are contained in the appropriate provider manuals. Resident trust fund reviews will be conducted at fifty (50) percent of the affected facilities on an annual basis. The resident trust fund accounts of each facility will be reviewed at least every two years. Results of the resident trust fund reviews will be reported to the Mississippi State Department of Health, Division of Health Facilities Licensure and Certification. The Division of Medicaid may impose certain sanctions, established by the Division of Medicaid, on those facilities found to be in non-compliant status, based on criteria approved by the Division of Medicaid.

1-5 Admission, Transfer, and Discharge Rights

The facility must establish and practice admission, discharge, and transfer policies which comply with federal and state regulations. Long-term care facilities that participate in the Medicaid program are prohibited from requiring any resident or any resident's family member or representative to give a notice prior to discharge in order to require payment from that resident, family member or representative for days after the discharge date.

1-6 Payments to Providers

A. Acceptance of Payment

Participation in the Title XIX Program will be limited to those providers that agree to accept, as payment in full, the amounts

paid by the Division of Medicaid plus any deductible, coinsurance or co-payment required by the plan to be paid by the individual for all covered services provided to Medicaid patients.

B. Assurance of Payment

The State will pay a certified Title XIX long-term care facility with a valid provider agreement, furnishing services in accordance with these and other regulations of the Mississippi Medical Assistance Program in accordance with the requirements of applicable State and Federal regulations and amounts determined under this plan. Payment rates will be reasonable and adequate to meet the actual allowable costs of a facility that is efficiently and economically operated.

C. Upper limit based on Customary Charges

In no case may the reimbursement rate for services provided under this plan exceed an individual facility's customary charges to the general public for such services, applied in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge. The Division of Medicaid recognizes the requirement that facilities give notice to residents thirty (30) days in advance of a rate change. Presuming that facilities set their private pay rates on the first day of the month, if a facility receives notice from Medicaid less than thirty-five (35) days in advance of their Medicaid rate increase, additional time to properly notify their residents will be granted before the upper limit is applied. However, the facility must adjust the private pay rate as soon as possible and no later than sixty-seven (67) days following the receipt of the rate notification, in order to comply with this limit.

D. Overpayments

An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed in accordance with the provisions of this plan. Overpayments must be repaid to the Division of Medicaid within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the Division of Medicaid first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the Division of Medicaid in writing, whichever date is earlier. Failure to repay an overpayment to the Division of Medicaid may result in sanctions. Overpayments documented in audits will be accounted for on the Form CMS-64 Quarterly Statement of Expenditures not later than the second quarter following the quarter in which the overpayment was found.

E. Underpayments

An underpayment occurs when an amount which is paid by the Division of Medicaid to a provider is less than the amount that is computed in accordance with the provisions of this plan. Underpayments will be reimbursed to the provider within sixty (60) days after the date of discovery.

F. Credit Balances

A credit balance, or negative balance, on a provider's account is an amount which is due to the Division of Medicaid. The credit balance is treated as an overpayment by the Division of Medicaid and is subject to the rules described above for overpayments.

1-7 Appeals and Sanctions

A. Appeal Procedures - Desk and Field Reviews

Long-term care providers who disagree with an adjustment to their allowable costs made as a result of a desk review or an audit may file an appeal to the Division of Medicaid. The appeal must be in writing, must include the reason for the appeal and any supporting documentation, and must be made within thirty (30) calendar days after notification of the adjustment. The Division of Medicaid shall respond within thirty (30) calendar days after the receipt of the appeal.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

Long-term care providers who disagree with an adjustment to the Minimum Data Set (MDS) that changes the classification of the resident to a different M^3PI group than the M^3PI group originally determined by the facility may file an appeal to the Division of Medicaid. These adjustments may have been made by either a desk review or an on-site visit. The appeal must be in writing, must contain the reason for the appeal and any supporting documentation, and must be made within thirty (30) calendar days after the provider was notified of the adjustment. The Division of Medicaid shall reply within thirty (30) calendar days after the receipt of the appeal.

Notices and responses shall be delivered by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery, and shall be deemed to have been received (a) if by certified mail or overnight mail, on the day the delivery receipt is signed, or (b) if by hand delivery, on the date delivered.

The provider may appeal the decision of the Division of Medicaid in matters related to cost reports, including, but not limited to, allowable costs and cost adjustments resulting from desk reviews and audits in accordance with Medicaid policy.

The provider may appeal the decision of the Division of Medicaid in matters related to the Minimum Data Set (MDS) including but not limited to audits, classifications and submissions in accordance with Medicaid policy.

The action of the Division of Medicaid under review shall be stayed until all administrative proceedings have been exhausted.

Appeals by nursing facility providers involving any issues other than those specified above in this section shall be taken in accordance with the administrative hearing procedures set forth in Medicaid policy.

B. Grounds for Imposition of Sanctions

Sanctions may be imposed by the Division of Medicaid against a provider for any one or more of the following reasons:

a. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, records of services provided to Medicaid recipients and records of payment made therefrom.

b. Failure to provide and maintain quality services to Medicaid recipients within accepted medical community standards as adjudged by the Division of Medicaid or the MS Department of Health.

c. Breach of the terms of the Medicaid Provider Agreement or failure to comply with the terms of the provider certification as set out on the Medicaid claim form.

d. Documented practice of charging Medicaid recipients for services over and above that paid by the Division of Medicaid.

e. Failure to correct deficiencies in provider operations after receiving written notice of deficiencies from the Mississippi State Department of Health or the Division of Medicaid.

f. Failure to meet standards required by State or Federal law for participation.

g. Submission of a false or fraudulent application for provider status.

h. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.

i. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.

j. Violating a Medicaid recipient's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.

k. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.

l. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.

m. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

n. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Conviction of a criminal offense relating to performance of a provider agreement with the State, or for the negligent practice resulting in death or injury to patients.

q. Failure to submit timely and accurately all required resident assessments.

r. Submitting, or causing to be submitted, false information for the purpose of obtaining a greater case mix facility average score in order to increase reimbursement above what is allowed under the plan.

s. Non-compliance with requirements for the management of recipients' personal funds, as stated in 42 CFR, Section 483.10, and as hereafter amended.

t. Failure to submit timely and accurately all required cost reports.

C. Sanctions

After all administrative proceedings have been exhausted, the following sanctions may be invoked against providers based on the grounds specified above:

A. Suspension, reduction, or withholding of payments to a provider,

B. Imposition of Civil Money Penalties upon Medicaid only, Title XIX participating long-term care facilities found to be in noncompliance with division and certification standards in accordance with federal and state regulations, including interest at the same rate calculated by the Department of Health and Human Services and/or the Centers for Medicare and Medicaid Services under federal regulations set forth in CFR 42, Section 488.400 - 488.456 and as hereafter amended.

C. Suspension of participation in the Medicaid Program, and/or

D. Disqualification from participation in the Medicaid Program.

Under no circumstances shall any financial loss caused by the imposition of any of the above sanctions be passed on to recipients, their families or any other third party.

~~1-8 Public Notification~~

1-8 Public Notification

Public notice of any changes in the statewide methods and standards for setting payment rates shall be provided as required by applicable law.

1-9 Plan Amendments

Amendments to the Mississippi Medicaid State Plan will be made in accordance with Section 43-13-117 of the Mississippi Code of 1972.

The state has in place a public process which complies with the requirements of Section 1902(a) (13) (A) of the Social Security Act and 42 CFR, section 447.205.

1-10 Special Services

A. Swing Bed Services

Reimbursement. Swing-bed providers will be reimbursed for the eligible days of care rendered Medicaid recipients in each calendar month. The rates will be redetermined annually for the reimbursement period July 1 through June 30. The methods and standards for determining the

CHAPTER 2

STANDARDS FOR ALLOWABLE COSTS

-1 Allowable and Non-Allowable Costs

ıe Division of Medicaid defines allowable and non-allowable costs to identi ‹penses which are reasonable and necessary to provide care to Nursing Facilit ?TF and ICF-MR residents. The standards listed below are established to provic ıidance in determining whether certain selected cost items will be recognized ɛ llowable costs. In the absence of specific instructions or guidelines in th an, facilities will submit cost data for consideration for reimbursement llowable costs must be compiled on the basis of generally accepted accountir rinciples (GAAP). In cases where Division of Medicaid cost reporting rule onflict with GAAP, IRS or CMS PRM 15-1, Division of Medicaid rules tal recedence for Medicaid provider cost reporting purposes. Allowable costs aı ased on CMS PRM 15-1 standards except as otherwise described in this plan.] ıe Division of Medicaid classifies a particular type of expense as non-allowab or the purpose of determining the rates, it does not mean that individuɛ roviders may not make expenditures of this type.

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A. Allowable Costs

In order for a cost to be an allowable cost for Medicaid reimbursement purposes, it must be reasonable and necessary in the normal conduct of operations related to providing patient care in accordance with CMS PRM 15-1 guidelines.

The following list of allowable costs is not comprehensive, but serves a general guide and clarifies certain key expense areas. The absence of a particular cost does not necessarily mean that it is not an allowable cost.

1. Accounting Fees. Accounting fees incurred for the preparation of the cost report, audits of the financial records, bookkeeping services, tax return preparation of the nursing facility and other related services are allowable costs. Accounting fees incurred for personal tax planning and income tax preparation of the owner are not allowable costs.

2. Advertising Costs - Allowable. The allowability of advertising costs depends on whether they are appropriate and helpful in developing, maintaining, and furnishing

covered services to Medicaid recipients by providers of services. In determining the allowability of these costs, the facts and circumstances of each provider situation as well as the amounts which would ordinarily be paid for comparable services by comparable institutions will be considered. To be allowable, such costs must be common and accepted occurrences in the field of the provider's activity.

Advertising costs incurred in connection with the provider's public relations activities are allowable if the advertising is primarily concerned with the presentation of a good public image and directly or indirectly related to patient care. Examples are: visiting hours information, conduct of management-employee relations, etc. Costs connected with fund-raising are not included in this category.

Costs of advertising for the purpose of recruiting medical, paramedical, administrative and clerical personnel are allowable if the personnel would be involved in patient care activities or in the development and maintenance of the facility.

3. Barber and Beauty Expense. The cost of providing barber and beauty services to residents is considered an allowable cost only if the residents are not charged for these services.

4. Board of Directors Fees. Fees paid to board members for actual attendance at Board of Directors' meetings are allowable costs, subject to the test of reasonableness. For this purpose, the table below will assist in the determination of reasonable fees. Related travel expenses, as long as determined reasonable, will also be considered an allowable cost. This table is effective for the calendar year 1991. The Division of Medicaid will update the table annually based on the change in the Consumer Price Index for all urban consumers (all items). The Division of Medicaid will issue a new table each year that will contain the limitations, as computed above, for the previous calendar year. The new limits will be published in the Medicaid Bulletin. The table for calendar year 1991 is as follows:

6. Contract Labor. This includes, but is not limited to, payments for contract registered nurses, licensed practical nurses, aides, therapists, dietary services, housekeeping services and maintenance services and agreements.

7. Depreciation Expense. Assets purchased for an amount less than or equal to $500 should be included in allowable costs as a current period expense. Assets purchased on or after January 1, 1992, excluding vehicles, for an amount greater than $500 but less than the amount determined to be the cost of a new bed as defined in Chapter 3 for nursing facilities, Chapter 4 for ICF-MR's, or Chapter 5 for -PRTF's should be depreciated using the straight line method over three (3) to five (5) years. Vehicles purchased for facility use that are related to patient care, which may have been purchased prior to January 1, 1992, should be depreciated using the straight line method over three (3) to five (5) years and the depreciation expense should be included in Administrative and Operating Costs on the cost report. Items, excluding

C. Social, Fraternal, and Other Organizations. Generally, these organizations concern themselves with activities unrelated to their members' professional or business activities. Their objectives and functions cannot be considered reasonably related to the care of recipients.

Consequently, provider costs incurred in connection with memberships in social, fraternal, and other organizations are not allowable.

9. Legal Fees. Legal fees are allowable if they are related to patient care or incurred in the usual and customary operations of a facility. Legal fees resulting from suits against federal and/or state agencies administering the Medicaid program are not allowable costs unless the provider prevails in their appeal or litigation.

10. Management Fees Paid to Related Parties and Home Office Costs. The allowability of the cost of management fees paid to related parties and home office costs will be based on CMS PRM 15-1 standards.

11. Management Fees Paid to Unrelated Parties. The allowability of the cost of purchased management services will be based on CMS PRM 15-1 standards.

12. Organization Costs. Organization costs are those costs directly incident to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and thus affect the costs of future periods of operation.

    Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and by-laws, legal agreements, minutes of organizational meeting, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to States for incorporation.

worked per week at all owned facilities can not exceed sixty hours for each individual to be considered allowable. This limitation applies for salaries that are paid by the facility and/or by the home office.

14. Personal Hygiene Items. The cost of routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, over-the-counter drugs that are not covered by the Mississippi Medicaid drug program, and basic personal laundry. Basic hair cuts and shampoos must be provided by the facility at no additional cost to the resident. Basic haircuts and shampoos may be done by facility staff or a licensed barber or beautician. If the facility elects to use a licensed barber or beautician, the resident may not be charged a fee for the service. Barber and beauty services requested by the resident that are in addition to basic haircuts and shampoos may be billed to the residents.

maintenance, housekeeping, and any other allowable costs incident to the start-up period. However, any costs that are properly identifiable as organization costs, or which may be capitalized as construction costs, must be appropriately classified as such and excluded from start-up costs.

Where a provider prepares all portions of its facility for patient care services at the same time and has capitalized start-up costs, the start-up costs must be amortized ratably over a period of sixty (60) consecutive months beginning with the month in which the first patient is admitted to the facility. Where a provider prepares portions of its facility for patient care services on a piecemeal basis, start-up costs must be capitalized and amortized separately for the portions of the provider's facility that are prepared for patient care services during different periods of time.

17. Supplies and Materials. This includes, but is not limited to, medical supplies, office, dietary, housekeeping, and laundry supplies; food and dietary

supplements; materials and supplies for the operation, maintenance and repair of buildings, grounds and equipment; bank service charges other than insufficient check charges; linens and laundry alternatives; and postage. Medical supplies necessary for the provision of care in order to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care are allowable costs. Any supplies or equipment ordered by a resident's attending physician must be provided by the facility and will be an allowable cost.

18. Therapy Expenses. Costs attributable to the administering of therapy services should be reported on Form 6, Line 2. Therapy expenses will be included in the per diem rate for PNFSD, PRTF and ICF/MR providers. Therapy expenses for Small Nursing Facilities and Large Nursing Facilities will be reimbursed on a fee for service basis.

Costs of advertising of a general nature designed to invite physicians to utilize a provider's facilities in their capacity as independent practitioners are not allowable.

Costs of advertising incurred in connection with the issuance of a provider's own stock, or the sale of stock held by the provider in another corporation, are considered reductions in the proceeds from the sale and, therefore, are not allowable.

Costs of advertising to the general public which seeks to increase patient utilization of the provider's facilities are not allowable. Situations may occur where advertising which appears to be in the nature of the provider's public relations activity is, in fact, an effort to attract more patients. An analysis by the Division of Medicaid or its contractor of the advertising copy and its distribution may then be necessary to determine the specific objective.

2. <u>Bad Debts.</u> Bad debts are not an allowable cost for Medicaid reimbursement purposes.

3. Barber and Beauty Expense. The cost of a barber and beauty shop located in the facility must be excluded from allowable costs if the residents are charged for these services. Costs to exclude include salaries and fringe benefits of barber and beauty shop staff, utilities, supplies and capital costs related to the square footage used for this purpose. If the facility does not submit a cost finding with the cost report, the revenue for barber and beauty services will be deducted from allowable costs. The cost of barber and beauty services provided to residents for which no charge is made should be included in care related costs in the allowable cost section of the cost report.

4. Contributions. Contributions are not an allowable cost. This includes political contributions and donations to religious, charitable, and civic organizations.

5. Feeding Assistant Training. Feeding Assistant training is a non-allowable cost. Reimbursement for feeding assistant training is made to the provider through direct billing.

6. Income Taxes - State and Federal. State and federal income taxes paid are not allowable costs for Medicaid reimbursement purposes.

7. Life Insurance - Officers, Owners and Key Employees. In general, the cost of life insurance on the officer(s), owner(s), key employee(s) where the provider is a direct or indirect beneficiary are not allowable costs. A provider is a direct beneficiary where, upon the death of the insured individual, the insurance proceeds are payable directly to the provider. A provider is an indirect beneficiary when another party receives the proceeds of a policy through an assignment by the provider to the party or other legal mechanism but the provider benefits from the payment of the proceeds to the third party.

An exception to these requirements is permitted where (1) a provider as a requirement of a lending institution must purchase insurance on the life of an officer(s), owner(s), or key employee(s) to guarantee the outstanding loan balance, (2) the lending institution must be designated as the beneficiary of the insurance policy, and (3) upon the death of the insured, the proceeds will be used to pay off the balance of the loan. The insurance premiums allowable are limited to premiums

equivalent to that of a decreasing term life insurance policy needed to pay off the outstanding loan balance. In addition, the loan must be related to patient care and be considered an allowable debt as described elsewhere in this plan.

8. Non-Nursing Facility Costs. Facilities which have a portion of the facility that is not certified for Medicaid should allocate the costs associated with that portion of the facility as non-allowable costs. These costs should be allocated based on square footage for fixed costs (i.e. utilities, depreciation, interest), actual salaries and fringe benefits of employees working in the non-certified area, and based on patient days for non-direct costs (i.e. administrative costs, dietary costs), or other methods which are acceptable by Medicare per CMS PRM 15-1 guidelines.

9. Nurse Aide Testing and Training. Nurse aide training and testing is a non-allowable cost. Reimbursement for nurse aide training and testing is made to the provider through direct billing.

10. Other Non-Allowable Costs. The cost of any services provided for which residents are charged a fee is a non-allowable cost. In addition, the amount paid for any item subject to direct reimbursement by the Division of Medicaid is a non-allowable cost.

11. Penalties and Sanctions. All penalties and sanctions assessed to the facility are considered non-allowable costs. These include, but are not limited to, delinquent cost report penalties, Internal Revenue Service penalties, civil money penalties, delinquent bed assessment penalties, and insufficient check charges.

12. Television. The cost of providing television service to residents is a non-allowable cost if residents are charged a fee for this service.

13. Vending Machines. The cost of providing vending machines is a non-allowable cost. If a cost finding is not submitted with the cost report, the vending machine revenues will be offset against allowable costs.

2-2 Nurse Aide Training and Competency Testing

Reasonable costs of training and competency testing of nursing assistants in order to meet the requirements necessary for the nursing assistants to be certified in accordance with the Omnibus Budget Reconciliation Act of 1987 are to be billed directly to the Division of Medicaid. The nursing facility will be directly reimbursed by the Division of Medicaid following policies stated in the Mississippi Medicaid Nursing Facility Manual. Payments made by Medicaid will be based on the facility's Medicaid utilization percentage which will be calculated for each state fiscal year. Each facility's percentage will be calculated once for each fiscal year, no more than forty-five (45) days in advance of the start of the state fiscal year and will be based upon data from the most recent cost report available. Facilities which change ownership will use the old owner's percentage for the remainder of the fiscal year. A facility's interim percentage will be eighty percent (80%) if no cost report data is available. The percentage will be adjusted to actual upon receipt of a cost report; the adjustment will not be retroactive. The training costs must be incurred for an employee of a Medicaid participating nursing facility who attends a program approved by the Mississippi State Department of Health. Nursing facilities must account for and request for reimbursement for training and competency testing costs in accordance with policies and procedures adopted in the Mississippi Medicaid Nursing Facility Manual. All costs billed to the Division of Medicaid are subject to verification of the expense prior to being processed for payment. The Division of Medicaid shall claim these expenses as administrative costs on the CMS-64 Quarterly Statement of Expenditures.

Each facility must establish and follow a written bed-hold and resident return policy which conforms to requirements of the Medicaid State Plan and other state and federal regulations. Hospital leave days may not be billed if the facility refuses to readmit the resident under their resident return policy. Repayment will be required of a facility which bills Medicaid for fifteen (15) days of hospital leave, discharges the resident, and subsequently refuses to readmit the resident under their resident return policy when a bed is available. Leave days must be billed in accordance with the applicable Division of Medicaid provider manual.

B. Home/Therapeutic Leave

The Division of Medicaid will reimburse long-term care facilities for home/therapeutic leave days with limits per resident, per state fiscal year (July 1 - June 30), as determined by the Mississippi State Legislature. Nursing Facility residents are allowed fifty-two (52) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. ICF-MR residents are allowed eighty-four (84) days per state fiscal year in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. PRTF residents are allowed eighteen (18) days per state fiscal year. Leave days must be determined, authorized and billed in accordance with the applicable Division of Medicaid provider manual.

C. Bed Hold Days Payment

A facility will be paid its per diem rate for the allowed bed hold days. For purposes of calculating the case mix average of the facility, residents on allowable leave will be classified at the lower of the case mix weight as computed for the resident on leave using the assessment being utilized for payment at the point in time the resident starts the leave, or a case mix score of 1.000.

2-6 Feeding Assistant Training

Reasonable costs of training feeding assistants in order to meet the requirements necessary to certify feeding assistants in accordance with 42 CFR, Section 483.35 (4) (2) are to be billed directly to the Division of Medicaid. Nursing facilities must account for and request reimbursement of training costs in accordance with policies and procedures adopted in the Mississippi Medicaid Nursing Facility Manual. The nursing facility will be directly reimbursed by the Division of Medicaid. The expenses will be subject to verification prior to processing the payment. Payments made by Medicaid will be based on the facility's Medicaid utilization percentage used for nurse aide training and testing reimbursement. The Division of Medicaid shall claim these expenses as administrative costs on the CMS-64 Quarterly Statement of Expenditures report.

CHAPTER 3

RATE COMPUTATION - NURSING FACILITIES

3-1 Rate Computation - Nursing Facilities - General Principles

It is the intent of the Division of Medicaid to reimburse nursing facilities a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care and care related costs greater than 90% of the median and less than the maximum rate, therapy costs of PNFSD less than the maximum rate, administrative and operating costs of less than the maximum rate, property costs that do not require a payment of the hold harmless provision and an occupancy rate of 80% or more.

3-2 Resident Assessments

All nursing facilities shall complete a Minimum Data Set assessment on all residents, in accordance with the policies adopted by the Division of Medicaid and CMS.

A. Submission of MDS Forms. Assessments of all residents must be submitted electronically.

Data processing on all assessments started within a calendar quarter will be closed on the fifth (5th) day of the second (2nd) month following the quarter, e.g., the MDS's with start

dates between July 1, 1996 and September 30, 1996 will be closed out for the final calculations on November 5, 1996. This allows a full month for the submission and correction of all MDS's begun in a calendar quarter. Assessments for a specific quarter which are received after the file has been closed will not be entered for previous quarterly calculations but will be reflected in subsequent quarterly calculations and in the annual report.

The submission schedule may be extended as deemed necessary by the Division of Medicaid for extenuating circumstances. This will include the dates of submission following the end of a calendar quarter and the use of assessments received after the cut-off date.

B. Assessments Used to Compute a Facility's Average Case Mix Score. All resident assessments completed per a calendar quarter will be used to compute the quarterly case mix average for a facility. These will include the last assessment from the previous calendar quarter. Therapeutic leave, hospital leave and bed hold days will be calculated

at the lower of the case mix weight as computed for the resident on leave using the assessment being utilized for payment at the point in time the resident starts the leave, or a case mix score of 1.000. Assessments used in the computation will affect the case mix computation using the start date of the assessment except for new admissions and readmissions. The computation of the facility's case mix score will use the date of admission for new admissions or residents that are readmitted after a discharge from the facility. In computing a facility's average case mix, the dates of admission or readmission will be counted and the dates of discharge will not be counted in the computation.

C. Audits of the MDS. The accuracy of the MDS will be verified by Registered Nurses. At least ten percent (10%) of the residents in the facility will be selected for the sample. The sample should include at least one resident from each major classification group. Residents may be added to the minimum sample as deemed appropriate by the review nurse(s) and/or other case mix staff. The sample will not be limited to Title XIX recipients since the total case mix of the facility will be used in computing the per diem rate. If more than twenty-five percent (25%) of the sample assessments are found to have errors which change the classification of the resident, the sample will be expanded.

Policies adopted by the Division of Medicaid will be used as a basis for changes in audits of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing audits.

D. Roster Reports and Bed Hold Reports.

Roster Reports are available to all facilities electronically. Roster Reports should be checked by the facilities to determine if all assessments completed by the facility have been entered into the Division of Medicaid case mix database and if all discharge dates are reflected on the report. Missing assessments and discharge dates should be submitted electronically before the due date listed on the report. If the due date is on a weekend or a State of Mississippi holiday or a federal holiday, the data should be submitted on or before the first business day following such weekend or holiday.

Final quarterly Roster Reports will be available electronically to facilities. Even though it is too late to submit data to affect a closed quarter, any missing assessments or discharge dates should be submitted electronically in order to be reflected on the next quarter's Roster Report.

Bed Hold Reports should be reviewed by the facility to determine if all hospital and home/therapeutic leave has been properly reported. Corrections to bed hold days should be submitted to the Division of Medicaid electronically.

schedule required by the Division of Medicaid.

3-3 Resident Classification System

The Division of Medicaid will use the M^3PI to classify nursing home residents so a facility case mix average may be computed. This classification system utilizes specific items from the MDS to assign residents to categories which reflect the resident's functional status as well as resource utilization to meet resident care needs. The M^3PI contains thirty-four (34) total groups and is based on a descending hierarchical order ranging from most resource intense to least resource intense. (The graphic depiction of the classification hierarchy included at the end of this section provides a visual representation of this narrative).

For nursing facility rates established for dates of service on or after January 1, 1999, the Division shall utilize version 5.12 of the Mississippi M^3PI. Version 5.12 of the Mississippi M^3PI uses the same grouper methodology as the CMS version 5.12 of the RUGS-III classification system with the 34 group logic.

reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the next calendar rate year. For example, the rates effective January 1, 2001 will be determined from cost reports filed for the year ended June 30, 1999 for state owned facilities, for the year ended September 30, 1999 for county owned facilities and for the year ended December 31, 1999 for all other facilities, unless a short period cost report and rate calculation is required by other provisions of this plan.

A description of the calculation of the per diem rate is as follows:

A. Direct Care Base Rate and Care Related Rate Determination

Direct care costs include salaries and fringe benefits for registered nurses (RN's),(excluding the Director of Nursing, the Assistant Director of Nursing and the Resident Assessment Instrument (RAI) Coordinator); licensed practical nurses (LPN's); nurse aides; feeding assistants; contract RN's, LPN's, and nurse aides, medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

Care related costs include salaries and fringe benefits for activities, the Director of Nursing, the Assistant Director of Nursing, RAI Coordinator, pharmacy and social services. It also includes barber and beauty expenses for which the residents are not charged, raw food and food supplements, consultants for activities, nursing, pharmacy, social services and therapies, the Medical Director, and supplies used in the provision of care related services.

1. **Calculate the average case mix score for each facility during the facility's cost report period. [Divide the case mix adjusted patient days (the sum of the patient days multiplied by Mississippi Base Weights) by total period patient days.]**
2. **Determine the per diem direct care cost for each facility during the cost report period. (Divide direct care cost by total period patient days.)**
3. **Divide each facility's per diem direct care cost by its case mix score as determined in 1, above. The result is the facility's case mix adjusted direct care per diem cost. This adjustment expresses each facility's direct care costs as if the facility had a case mix of 1.00.**
4. **Add the per diem care related cost for each facility to the case mix adjusted direct care per diem cost calculated in 3, above.**
5. **Trend forward each facility's case mix adjusted direct care and care related cost per diem to the middle of the rate year using the trend factor. This is done by multiplying the trend factor by a mid-point factor. The mid-point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.**

6. Determine the ceiling and floor for direct care and care related costs together for small and large nursing facilities and separately for PNFSD's as follows:

   A. Prepare an array of the small and large nursing facilities; their associated trended direct care and care related costs, summed; and their annualized total patient days. Prepare a separate array of the PNFSD's.

   B. Arrange the data in order from lowest to highest cost for each array.

   C. Add to each array the cumulative annualized total patient days by adding in succession the days listed for each facility.

   D. Determine the median patient days by multiplying the total cumulative patient days by fifty percent (50%) and locate the median patient days on each array.

   E. Determine the median costs by matching the median patient days to the cost associated with the median patient day for each array. This may require interpolation.

   F. The ceiling for direct care and care related costs is determined by multiplying the median cost for each array by one hundred twenty percent (120%). The floor is

will be determined by multiplying the standard direct care rate by the average case mix for the quarter January 1, 1993 through March 31, 1993. This will result in the case mix adjusted direct care per diem rate. This is added to the care related per diem rate, the therapy per diem rate for PNFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, the per diem hold harmless, and the per diem return on equity capital to compute the facility's total per diem rate for the calendar quarter. The direct care per diem base rate, the care related per diem rate, the therapy per diem for PNFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, the per diem hold harmless and the per diem return on equity capital are computed annually and are effective for the period January 1 through December 31. The case mix adjustment is done quarterly to determine the total rate for the periods January 1 through March 31, April 1, through June 30, July 1 through September 30, and October 1 through December 31.

D. Therapy Rate for Private Nursing Facilities for the Severely Disabled

Therapy costs include salaries and fringe benefits or contract costs of therapists and other direct costs incurred for therapeutic services.

1. Determine the per diem therapy cost for each Private Nursing Facility for the Severely Disabled during the cost report period. (Divide therapy cost by total period patient days.)
2. Trend each facility's therapy per diem cost to the middle of the rate year using the trend factor as defined in Chapter 7. This is done by multiplying the trend factor by a mid-point factor. The mid-point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.

fees, non-capital amortization, bank charges, board of directors fees, dietary supplies, depreciation expense for vehicles and for assets purchased that are less than the equivalent of a new bed value, dues, educational seminars, housekeeping supplies, professional liability insurance, non-capital interest expense, laundry supplies, legal fees, linens and laundry alternatives, management fees and home office costs, office supplies, postage, repairs and maintenance, taxes other than property taxes, telephone and communications, travel and utilities.

1. Determine the per diem administrative and operating cost for each facility during the cost report period. (Divide administrative and operating cost by total period patient days. Patient days will be increased, if less than 80% occupancy, to 80% occupancy.)
2. Trend each facility's administrative and operating per diem cost to the middle of the rate year using the trend factor as defined in Chapter 7. This is done by multiplying the trend factor by a mid-point factor. The mid-point factor allows costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period.
3. Determine the ceiling for administrative and operating costs for each classification as follows:
   A. Prepare an array for each nursing facility classification. Each array should include the facility names, their associated trended administrative and operating costs, and their annualized total patient days.
   B. Arrange the data in each array from lowest to highest cost.

report used to set rates. Patient days for the cost report period will be adjusted, if less than 80% occupancy, to 80% occupancy.

6. Property taxes and property insurance will be annualized and divided by annualized total patient days from the cost report being used to set the rate to determine a per diem amount for these costs. Newly constructed facilities may submit documentation from the Tax Collector showing what taxes were paid for the rate period. These costs will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy. Leased facilities with property taxes or insurance included in the rental payments must provide documentation of these expenses in order for them to be included in the property payment. Facilities which have an increase in their taxes by fifteen percent (15%) or more may submit a copy of their tax bill in order to have their rate adjusted.
7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.
8. The hold harmless provision for capital costs must be computed as described in Chapter 6 of this plan to determine the per diem hold harmless payment for each facility.

by annualized patient days during the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated therewith, and those assets and liabilities which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

The average of the net working capital computed for the beginning and ending of the reporting period will be used for purposes of determining the net working capital eligible for a return on investment. The following are examples of items not included in the computation for net working capital:

a. Property, plant, and equipment, excluding vehicles;

b. Debt related to property, plant, and equipment, excluding vehicles;

c. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;

H. Total Base Rate

The annual base rate is the sum of the standard direct care per diem rate, the care related per diem rate, the administrative and operating per diem rate, the per diem property payment, the per diem hold harmless payment, and the per diem return on equity payment. The annual base rate for PNFSD's also includes the therapy per diem rate.

I. Calculation of the Rate for One Provider

In years when the rate is calculated for only one PNFSD, reimbursement will be based upon allowable reported costs of the facility. Reimbursement for direct care, therapies, care related, and administrative and operating costs will be calculated at cost plus the applicable trend factors. Reimbursement for administrative and operating costs will be subject to the ceiling for the facility as described in Section 3-4 E. The property payment and the return on equity payment will be calculated for the facility as described in Sections 3-4 F and G.

3-5 Occupancy Allowance

The per diem rates for fixed administrative and operating costs, care related costs and property costs will be calculated using the greater of the facility's actual occupancy level or eighty percent (80%). This level is considered to be the minimum occupancy level for economic and efficient operation. This minimum occupancy level will not be applied to the computation of patient days used to calculated the direct care and therapy rates, or the variable portion of the administrative and operating and care related rates.

For facilities having less than eighty percent (80%) occupancy, the number of total patient days will be computed on an eighty percent (80%) factor instead of a lower actual percentage of occupancy. For example: a facility with an occupancy level of seventy percent (70%) representing 20,000 actual patient days in a reporting period will have to adjust this figure to 22,857 patient days ((22,000 / 70%)

5. The annual fair rental value will be divided by the facility's annualized total patient days during the cost report period to determine the fair rental per diem payment. Annualized total patient days will be adjusted to reflect changes in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report used to set rates. Patient days will be adjusted, if less than 80% occupancy, to 80% occupancy.
6. Property taxes and property insurance will be annualized and divided by annualized total patient days to determine a per diem amount for these costs and will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy.
7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.
8. The hold harmless provision for capital costs must be computed as described in Chapter 6 of this plan to determine the per diem hold harmless payment for each facility.

C. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the rental factor used in the property payment to determine the return on equity payment. The return on equity payment will be divided by annualized patient days for the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated therewith, and those assets and liabilities

per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of 2% will be added to the index value. The rental factor is multiplied by the facility's total value as determined in 3, above, to determine the annual fair rental value.

5. The annual fair rental value will be divided by the facility's annualized total patient days during the cost report period to determine the fair rental per diem payment. Annualized total patient days will be adjusted to reflect changes in the number of certified beds by applying to the increase or decrease the occupancy rate reported on the cost report used to set rates. Patient days will be adjusted, if less than 80% occupancy, to 80% occupancy.

6. Property taxes and property insurance will be annualized and divided by annualized total patient days to determine a per diem amount for these costs. These costs will be passed through as an addition to the fair rental per diem payment. Patient days will be adjusted to reflect changes in the number of certified beds and, if less than 80% occupancy, to 80% occupancy.

7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.

8. The hold harmless provision for capital costs must be computed as described in Chapter 6 of this plan to determine the per diem hold harmless payment for each facility.

C. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the rental factor used in the property payment to determine the return on equity payment. The return on equity payment will be divided by annualized patient days for the cost report period used to set the rate to calculate the per diem return on equity payment. Patient days will be adjusted to reflect changes in the number of certified beds, and if less than 80% occupancy, to 80% occupancy. The facility's net working capital will be limited to two (2) months of the facility's allowable costs, including property-related costs. In effect, net working capital is the net worth of the provider (owners' equity in the net assets as determined under the Medicaid program) **excluding** net property, plant, and equipment, and liabilities associated therewith,

CHAPTER 7

TREND FACTORS

7-1 Trend Factor - General Principles

The trend factor is a statistical measure of the change in the costs of goods and services purchased by long term care facilities during the course of one year. The intent of the trend factor is to provide the Division of Medicaid with insight into the amount and nature of change of health care costs experienced by long term care providers.

7-2 Trend Factor Computation

A trend factor will be computed each year for long term care facilities and will be used in the calculation of the base rates effective for the rate year, January 1 through December 31. A separate trend factor will be calculated for direct care costs and care related costs, for therapy costs, and for administrative and operating costs. These trend factors will be computed as described below.

A. Cost Reports Used in the Calculation of the Trend Factors

Cost reports used in the computation of the trend factors are as described below.

1. Separate the costs into the following cost categories as defined in the cost report form:
   a. Direct Care Expenses (Form 6, Section 1)
   b. Therapies (Form 6, Section 2)
   c. Care Related Expenses (Form 6, Section 3)
   d. Administrative and Operating Costs(Form 6, Section 4)

2. Determine the relative weight of each of the line items in each category. A trend factor will not be developed for property costs because the value of each nursing facility bed will be indexed using the RS Means Construction Index for use in the fair rental reimbursement computation.

3. Obtain the market basket of economic indicators. An example of this market basket follows Section 7-6 of this plan.

4. The economic indicators for each line item of cost will be multiplied by the relative weight of the Form 6 line items in order to determine the trend factor for each line item. An example of the computation of the trend factors, using weighted

averages, is shown in Section 7-7 of this plan.

5. Add the line item trend factors determined in (4) above for each cost category. The result will be the trend factor for each of the cost categories.

6. The forecasted trend factor for each of the cost centers may be adjusted due to the following:
   a. Known increases or decreases in costs due to federal or state laws or regulations, or
   b. Other factors that can be reasonably forecasted to have a material effect on costs in the prospective year.

7-3 Trend Factors - Nursing Facilities

Trend factors will be used in computing the base rates for nursing facilities. A direct care and care related costs trend factor will be determined by combining the trend factors determined for each of these cost centers as determined in Section 7-2. The total Direct Care and Care Related Trend Factor will be computed by weighting the total allowable costs in each of the cost centers to the total costs for the two (2) cost centers. The percent of each cost center to total costs will be multiplied by the individual trend factors to determine an adjusted trend factor. The total of the two adjusted trend factors will be the direct care and care related costs trend factor.

NURSING FACILITY TREND FACTORS - 2004

COST CENTER	ALLOWABLE COSTS	TREND FACTOR	% OF TOTAL COSTS	ADJUSTED TREND FACTOR
Direct Care	$216,911,547	6.14%	77.93%	4.79%
Care Related	61,417,034	4.14%	22.07%	0.91%
DC/CR Trend Factor	$278,328,581		100.00%	**5.70%**
Therapy				
Trend Factor	**$ 17,048,995**	**6.32%**	**100.00%**	**6.32%**
Administrative and Operating Trend Factor	$188,448,481	8.75%	100.00%	**8.75%**

For example: The trend factor for direct care costs was determined to be 6.14% and the trend factor for care related costs was determined to be 4.14% in the trend factor computation example shown in Section 7-7, computed in accordance with Section 7-2. The total allowable costs for these cost centers was $216,911,547 for direct care costs and $61,417,034 for care related costs for a total of $278,328,581. Direct care costs made up 77.93% and care related costs amounted to 22.07% of the total for these two cost centers. Accordingly, the trend factor for direct care costs was multiplied by 77.93% and the trend factor for care related costs was multiplied by 22.07% in order to compute the Direct Care and Care Related Costs Trend Factor. The result in the example is (6.14% X

77.93%) + (4.14% X 22.07%) = 5.70% direct care and care related trend factor. The therapy trend factor in the example is 6.32%. The administrative and operating trend factor in the example is 8.75%.

7-4 Trend Factor - PRTF's and ICF-MR's

One (1) trend factor will be used in computing the rates for PRTF's and ICF-MR's. A trend factor will be determined by combining the trend factors determined for each cost center, as determined in Section 7-2. The PRTF and ICF-MR trend factor will be computed by weighting the total allowable costs in each of the four (4) cost centers to the total costs of the four (4) cost centers. The percent of each cost center to total costs will be multiplied by the individual trend factors to determine an adjusted trend factor. The total of the adjusted trend factors will be the PRTF and ICF-MR trend factor. For example:

PRTF and ICF-MR TREND FACTORS - 2004

Cost Center	Allowable Costs	Trend Factor	% of Total Costs	Adjusted Trend Factor
Direct Care	$216,911,547	6.14%	44.83%	2.75%
Therapies	17,048,995	6.32%	3.52%	0.22%
Care Related	61,417,034	4.14%	12.70%	0.53%
Admin./Oper.	188,448,481	8.75%	38.95%	3.41%
Total	$483,826,057		100.00%	**6.91%**

In this example the PRTF and ICF-MR Trend Factor is 6.91%.

7-5 Mid-Point Factor

A mid-point factor is applied separately for each facility to allow costs to be trended forward from the mid-point of the cost report period to the mid-point of the payment period. The applicable mid-point factor is multiplied by each trend factor The adjusted trend factor is then used to determine each facility's trended costs. The mid-point factor is calculated by counting the number of months from the mid-point of the cost report period to the mid-point of the payment period. This number of months is divided by twelve (12). The product is the mid-point factor. The mid-point factor for a calendar year cost report being used to set rates for the second following calendar year is 2.0. For example, the mid-point factor is 2.0 when the cost report for January 1, 2002 through December 31, 2002 is used to set rates for the payment period January 1, 2004 through December 31, 2004. This is calculated by first determining the mid-points of both the cost report period and the payment period, July 1, 2002 and July 1, 2004, respectively. The number of months between the two mid-points in this example is twenty-four (24). Twenty-four (24) divided by twelve (12) equals 2.0.

The mid-point factor is multiplied by each applicable trend factor for a facility. Using the trend factors in Sections 7-3 and 7-4, the adjusted 2004 trend factors for a 2002 calendar cost report filer would be as follows:

Cost Center(s)	**Trend Factor**	**Mid-Point Factor**	**Adjusted Trend Factor**
Direct Care/ Care Related	5.70%	2.0	.114000
Therapy	6.32%	2.0	.126400
Administrative and Operating	8.75%	2.0	.175000
Direct Care, Therapies, Care Related, Admin./Operating	6.91%	2.0	.138200

7-6 Market Basket of Economic Indicators Example

CPI						
SERIES ID	ITEM	EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
SAM2	Medical Care Services	Group Health Insurance	1-05, 2-06, 3-08, 4-11	278.8	292.9	5.1%
SAA	Apparel	Uniform Allowance	1-08, 2-09, 3-11, 4-14	127.3	124	-2.6%
SAM1	Medical Care Commodities	Drugs	1-13	247.6	256.4	3.6%
		Medical Supplies	1-14			
SEHG02	Garbage and Trash Collection	Medical Waste Disposal	1-15	275.5	283	2.7%
SEGC01	Haircuts and Other Personal Care Services	Barber & Beauty Expense	3-13	112.5	114.9	2.1%
SEMC04	Services by Other Medical Professionals	Consultant Fees - Activities	3-14	167.3	171.8	2.7%
		Consultant Fees - Nursing	3-16			
		Consultant Fees - Pharmacy	3-17			
		Consultant Fees - Social Worker	3-18			
		Consultant Fees - Therapists	3-19			
SEMC01	Physicians' Services	Consultant Fees - Medical Director	3-15	253.6	260.6	2.8%
SAF	Food and Beverages	Food - Raw and Supplements	3-20, 3-21	173.6	176.8	1.8%
SEHP	Household Operations	Contract - Dietary	4-16	115.6	119	2.9%
		Contract - Housekeeping	4-17			
		Contract - Maintenance	4-19			
		Repairs and Maintenance	4-42			
SEGD03	Laundry and Dry Cleaning Services	Contract - Laundry	4-18	109.9	113.2	3.0%
SEGD	Miscellaneous Personal Services	Consultant Fees - Dietician	4-20	263.1	274.4	4.3%
		Consultant Fees - Medical Records	4-21			
SS68023	Tax Return Preparation and Other Accounting Fees	Accounting Fees	4-22	121.2	127.5	5.2%
SETA	New and Used Motor Vehicles	Auto Lease	4-24	101.3	99.2	-2.1%
SS68021	Checking Account and Other Bank Services	Bank Service Charges	4-25	113.7	116.9	2.8%
SAS	Services	Board of Directors Fees	4-26	203.4	209.8	3.1%
SEHN	Housekeeping Supplies	Dietary Supplies	4-27	158.4	159.8	0.9%
		Housekeeping Supplies	4-31			
		Laundry Supplies	4-34			
SAH3	Household Furnishings and Operations	Depreciation	4-28	129.1	128.3	-0.6%
SEGD01	Legal Services	Legal Fees	4-35	199.5	211.1	5.8%
SEHH03	Other Linens	Linen and Laundry Alternatives	4-36	96	93.2	-2.9%
SAT	Transportation	Non-Emergency Transportation	4-39	154.3	152.9	-0.9%

CPI						
SERIES ID	ITEM	EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
SEEC	Postage and Delivery Services	Postage	4-41	107.3	113.7	6.0%
SEED	Telephone Services	Telephone & Communications	4-44	99.3	99.7	0.4%
SA0	All Items	Travel	4-45	177.1	179.9	1.6%
SAH2	Fuels and Utilities	Utilities	4-46	150.2	143.6	-4.4%
SA0L1E	All Items Less Food and Energy	Other Supplies - Direct Care	1-16	186.1	190.5	2.4%
		Therapy Supplies	2-15			
		Supplies - Care Related	3-22			
		Amortization Expense	4-23			
		Dues	4-29			
		Educational Seminars & Training	4-30			
		Interest Expense	4-33			
		Miscellaneous Expense	4-37			
		Management Fees/ Home Office	4-38			
		Office Supplies and Subscriptions	4-40			
		Taxes - Other	4-43			
	OTHER INDICES	EXPENSE DESCRIPTION	COST REPORT LINE(S)	2001	2002	01-02
	MESC Average Weekly Wage on covered employment (NAICS 6231)	Salaries	1-01, 1-02, 1-03, 2-01, 2-02, 2-03, 2-04, 3-01, 3-02, 3-03, 3-04, 3-05, 3-06, 4-01, 4-02, 4-03, 4-04, 4-05, 4-06, 4-07, 4-08, 4-09	198.3	210.9	6.4%
		Contract - Aides	1-10			
		Contract - LPN's	1-11			
		Contract - RN's	1-12			
		Contract - OT	2-11			
		Contract - PT	2-12			
		Contract - ST	2-13			
		Contract - Other Therapists	2-14			
	FICA rates change with wage index	FICA	1-04, 2-05, 3-07, 4-10	222.5	236.7	6.4%
	PERS rate change with wage index	Pensions	1-06, 2-07, 3-09, 4-12	211.1	224.5	6.4%
	Worker's compensation and employer's liability. Classification code 8829 used with wage index	Worker's Compensation	1-09, 2-10, 3-12, 4-15	136.8	145.5	6.4%
	Wage Index	Unemployment Tax	1-07, 2-08, 3-10, 4-13	198.3	210.9	6.4%
	MHCISC or Other Available Study	Professional Liability Insurance	4-32	750	1300	73.3%

7-7 Trend Factor Computation Example

COST CENTER	LINE ITEM COST	PERCENTAGE OF COST CENTER	TREND FACTOR	WEIGHTED TREND FACTOR
Direct Care Costs				
Line 1-01, Salaries-Aides	91,682,061	42.27%	6.40%	2.71%
Line 1-02, Salaries-LPN's	49,940,472	23.02%	6.40%	1.47%
Line 1-03, Salaries-RN's	21,223,437	9.78%	6.40%	0.63%
Line 1-04, FICA Taxes-Direct Care	12,576,700	5.80%	6.40%	0.37%
Line 1-05, Group Health-Direct Care	10,377,862	4.78%	5.01%	0.24%
Line 1-06, Pension Plan-Direct Care	598,697	0.28%	6.40%	0.02%
Line 1-07, Unemployment Taxes-Direct Care	1,011,299	0.47%	6.40%	0.03%
Line 1-08, Uniforms-Direct Care	413,085	0.19%	-2.60%	0.00%
Line 1-09, Workmen's Comp-Direct Care	6,206,719	2.86%	6.40%	0.18%
Line 1-10, Contract-Aides	6,437,412	2.97%	6.40%	0.19%
Line 1-11, Contract-LPN's	1,520,643	0.70%	6.40%	0.04%
Line 1-12, Contract-RN's	1,777,912	0.82%	6.40%	0.05%
Line 1-13, Drugs - OTC and Legend	4,005,160	1.85%	3.60%	0.07%
Line 1-14, Medical Supplies	6,658,105	3.07%	3.60%	0.11%
Line 1-15, Medical Waste Disposal	511,655	0.23%	2.70%	0.01%
Line 1-16, Other Supplies-Direct Care	1,970,328	0.91%	2.40%	0.02%
Line 1-17, Allocated Costs, Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Direct Care Costs	$216,911,547	100.00%		6.1400%
Therapy Costs				
Line 2-01, Salaries-Occupational Therapists	306,165	1.80%	6.40%	0.12%
Line 2-02, Salaries-Physical Therapists	431,249	2.53%	6.40%	0.16%
Line 2-03, Salaries-Speech Therapists	261,529	1.53%	6.40%	0.10%
Line 2-04, Salaries-Other Therapists	1,936,608	11.36%	6.40%	0.73%
Line 2-05, FICA Taxes-Therapies	240,304	1.41%	6.40%	0.09%
Line 2-06, Group Health-Therapies	268,452	1.57%	5.01%	0.08%
Line 2-07, Pensions-Therapies	66,130	0.39%	6.40%	0.02%
Line 2-08, Unemployment Taxes-Therapies	21,455	0.13%	6.40%	0.01%
Line 2-09, Uniform Allowance-Therapies	6,266	0.03%	-2.60%	0.00%
Line 2-10, Workmen's Comp-Therapies	62,182	0.36%	6.40%	0.02%
Line 2-11, Contract-Occupational Therapists	3,542,127	20.78%	6.40%	1.33%
Line 2-12, Contract-Physical Therapists	4,386,198	25.73%	6.40%	1.65%
Line 2-13, Contract-Speech Therapists	1,846,379	10.83%	6.40%	0.69%
Line 2-14, Contract-Other Therapists	3,433,903	20.14%	6.40%	1.29%
Line 2-15, Therapy Supplies	240,048	1.41%	2.40%	0.03%
Line 2-16, Allocated Costs, Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Therapy Costs	$17,048,995	100.00%		6.3200%

COST CENTER	LINE ITEM COST	PERCENTAGE OF COST CENTER	TREND FACTOR	WEIGHTED TREND FACTOR
Care Related Costs				
Line 3-01, Salaries-Activities	5,136,257	8.36%	6.40%	0.54%
Line 3-02, Salaries-Assistant Director of Nursing	3,123,663	5.09%	6.40%	0.33%
Line 3-03, Salaries-Director of Nursing	7,777,076	12.66%	6.40%	0.81%
Line 3-04, Salaries Resident Assessment Instrument Coordinator	4,013,640	6.54%	6.40%	0.42%
Line 3-05, Salaries-Pharmacy	45,378	0.07%	6.40%	0.00%
Line 3-06, Salaries-Social Services	4,687,317	7.63%	6.40%	0.49%
Line 3-07, FICA Taxes-Care Related	2,061,706	3.36%	6.40%	0.22%
Line 3-08, Group Health-Care Related	1,824,792	2.97%	5.01%	0.15%
Line 3-09, Pension Plan-Care Related	376,240	0.61%	6.40%	0.04%
Line 3-10, Unemployment Taxes-Care Related	155,099	0.25%	6.40%	0.02%
Line 3-11, Uniforms, Care Related	112,715	0.18%	-2.60%	0.00%
Line 3-12, Workmen's Comp-Care Related	922,489	1.50%	6.40%	0.10%
Line 3-13, Allowable Barber & Beauty Expense	345,793	0.56%	2.10%	0.01%
Line 3-14, Consultant Fees-Activities	75,920	0.12%	2.70%	0.00%
Line 3-15, Consultant Fees-Medical Director	1,725,043	2.81%	2.80%	0.08%
Line 3-16, Consultant Fees-Nursing	1,477,260	2.41%	2.70%	0.07%
Line 3-17, Consultant Fees-Pharmacy	646,320	1.05%	2.70%	0.03%
Line 3-18, Consultant Fees-Social Worker	113,825	0.19%	2.70%	0.01%
Line 3-19, Consultant Fees – Therapists	42,012	0.07%	2.70%	0.00%
Line 3-20, Food-Raw	19,835,262	32.30%	1.80%	0.58%
Line 3-21, Food-Supplements	2,198,350	3.58%	1.80%	0.06%
Line 3-22, Supplies-Care Related	4,720,877	7.69%	2.40%	0.18%
Line 3-23, Allocated Costs, Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Care Related Costs	$61,417,034	100.00%		4.1400%
Administrative and Operating Costs				
Line 4-01, Salaries-Administrator	8,700,745	4.62%	6.40%	0.30%
Line 4-02, Salaries, Assistant Administrator	577,088	0.31%	6.40%	0.02%
Line 4-03, Salaries-Dietary	20,847,337	11.06%	6.40%	0.71%
Line 4-04, Salaries-Housekeeping	10,928,029	5.80%	6.40%	0.37%
Line 4-05, Salaries-Laundry	4,989,169	2.65%	6.40%	0.17%
Line 4-06, Salaries-Maintenance	5,154,790	2.74%	6.40%	0.18%
Line 4-07, Salaries-Medical Records	3,126,640	1.66%	6.40%	0.11%
Line 4-08, Salaries-Other Administrative	13,928,346	7.39%	6.40%	0.47%
Line 4-09, Salaries-Owner	1,135,719	0.60%	6.40%	0.04%
Line 4-10, FICA Taxes-Admin. & Operating	5,331,387	2.83%	6.40%	0.18%
Line 4-11, Group Health-Administrative	5,188,213	2.75%	5.01%	0.14%

COST CENTER	LINE ITEM COST	PERCENTAGE OF COST CENTER	TREND FACTOR	WEIGHTED TREND FACTOR
Administrative and Operating Costs, Cont.				
Line 4-12, Pension Plan-Administrative	575,803	0.31%	6.40%	0.02%
Line 4-13, Unemployment Taxes-Admin.	397,391	0.21%	6.40%	0.01%
Line 4-14, Uniforms-Administrative	207,546	0.11%	-2.60%	0.00%
Line 4-15, Workmen's Comp-Administrative	2,264,173	1.20%	6.40%	0.08%
Line 4-16, Contract-Dietary	433,573	0.23%	2.90%	0.01%
Line 4-17, Contract-Housekeeping	3,245,623	1.72%	2.90%	0.05%
Line 4-18, Contract-Laundry	2,309,604	1.23%	3.00%	0.04%
Line 4-19, Contract-Maintenance	971,411	0.52%	2.90%	0.02%
Line 4-20, Consultant Fees-Dietician	701,924	0.37%	4.30%	0.02%
Line 4-21, Consultant Fees-Medical Records	126,834	0.07%	4.30%	0.00%
Line 4-22, Accounting Fees	1,849,501	0.98%	5.20%	0.05%
Line 4-23, Amortization Expense - Non-Capital	91,710	0.04%	2.40%	0.00%
Line 4-24, Auto Lease	373,062	0.20%	-2.10%	0.00%
Line 4-25, Bank Service Charges	108,425	0.06%	2.80%	0.00%
Line 4-26, Board of Directors Fees	580,127	0.31%	3.10%	0.01%
Line 4-27, Dietary Supplies	2,032,753	1.08%	0.90%	0.01%
Line 4-28, Depreciation Expense	1,019,382	0.54%	-0.60%	0.00%
Line 4-29, Dues	704,978	0.37%	2.40%	0.01%
Line 4-30, Educational Seminars & Training	540,840	0.29%	2.40%	0.01%
Line 4-31, Housekeeping Supplies	2,406,546	1.28%	0.90%	0.01%
Line 4-32, Insurance-Professional Liability	13,651,905	7.24%	73.30%	5.31%
Line 4-33, Interest Expense-Non-Capital & Vehicle	805,570	0.42%	2.40%	0.01%
Line 4-34, Laundry Supplies	819,401	0.42%	0.90%	0.00%
Line 4-35, Legal Fees	1,216,909	0.65%	5.80%	0.04%
Line 4-36, Linen & Laundry Alternatives	2,662,787	1.41%	-2.90%	-0.04%
Line 4-37, Miscellaneous	1,010,396	0.54%	2.40%	0.01%
Line 4-38, Management Fees & Home Office	26,635,205	14.13%	2.40%	0.34%
Line 4-39, Non-Emergency Medical Transportation	573,025	0.30%	-0.90%	0.00%
Line 4-40, Office Supplies & Subscriptions	2,543,119	1.35%	2.40%	0.03%
Line 4-41, Postage	443,070	0.24%	6.00%	0.01%
Line 4-42, Repairs & Maintenance	6,595,366	3.50%	2.90%	0.10%
Line 4-43, Taxes, Other	14,280,784	7.58%	2.40%	0.18%
Line 4-44, Telephone & Communications	2,509,632	1.33%	0.40%	0.01%
Line 4-45, Travel	914,315	0.49%	1.60%	0.01%
Line 4-46, Utilities	12,938,328	6.87%	-4.40%	-0.30%
Line 4-47, Allocated Costs, Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Administrative & Operating Costs	$188,448,481	100.00%		8.7500%

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CHAPTER 8

DEFINITIONS

Annualized Total Patient Days - The total patient days reported on the cost report adjusted for any cost report period less than one year and for changes in the number of Medicaid-certified beds.. This is done to estimate what the total patient days would be for a full year for a facility. For example, a nursing facility files a cost report for three (3) months with total patient days of 10,000. The annualized total patient days would be (10,000 / 3) X 12 = 40,000. In this example, it is estimated that the total patient days for this facility would be 40,000.

Base Rate - A per diem rate established for nursing facilities that is set at least annually and is the equivalent of a case mix score of 1.0.

Care Related Costs - These costs include salaries and fringe benefits for activities, Director of Nurses, pharmacy, social services; food; Medical Director; consultants for activities, nursing, pharmacy, social services and therapies; related supplies; and personal hygiene supplies, other than linens and incontinence supplies.

Direct Care Costs - Expenses incurred by nursing facilities for the hands on care of the residents. These costs include salaries and fringe benefits for registered nurses (RN's), (excluding the Director of Nursing, the Assistant Director of Nursing and the Resident Assessment Instrument (RAI) Coordinator; licensed practical nurses (LPN's); nurse aides; feeding assistants; contract RN's, LPN's, and nurse aides; medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

Fair Rental System - The gross rental system as modified by the Mississippi Case Mix Advisory Committee and described in this plan.

Intermediate Care Facility for the Mentally Retarded (ICF-MR) - A classification of long term care facilities which provides services only for the mentally retarded or developmentally disabled in accordance with 42 CFR Part 483, Subpart I.

Minimum Data Set (MDS) - The resident assessment instrument approved by the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), for use by all Medicaid and Medicare certified nursing facilities in Mississippi including section S, as applicable.

Mississippi Access Weights - The Mississippi base weights increased by two percent (2%) for certain M^3PI groups listed in Section 3-4, B.

Mississippi Alzheimer's Unit Base Weights - A calculation, based on actual time and salary information of the care givers, of the relationship of each M^3PI group to the average for residents in licensed Alzheimer's Units.

Mississippi Base Weights - A calculation, based on actual time and salary information of the care givers, of the relationship of each M^3PI group to the average.

Multi-State Medicare Medicaid Payment Index (M^3PI) - The resident classification system developed for use by the Mississippi Medicaid Program. This classification system is based on assessments of residents and the time and cost associated with the care of the different types of residents.

Large Nursing Facility - A classification of long term care facilities which provides nursing facility care in accordance with 42 CFR Part 483, Subpart B and which has 61 or more beds certified for Title XIX.

Nursing Facility - Psychiatric - A classification of facilities now called Residental Psychiatric Treatment Facilities (PRTF).

Patient Days - The number of days of care charged to a recipient, including bed hold and leave days, for patient long term care is always counted in units of full days. A day begins at midnight and ends 24 hours later. The midnight-to-midnight method must be used in reporting the days of care for recipients, even if the facility uses a different definition for statistical or other purposes. The day of admission counts as a full day. However, the day of discharge

is not counted as a day. If both admission and discharge occur on the same day, the day is considered a day of admission and counts as one patient day.

Residential Psychiatric Treatment Facilities - A classification of facilities which provides long term psychiatric care for children under age 22, in accordance with 42 CFR, Part 441, Subpart D. Services must be provided under the direction of a physician who is at least board eligible and has experience in child/adolescent psychiatry. The psychiatric services must also be provided in accordance with an individual comprehensive services plan.

Small Nursing Facility - A classification of long term care facilities which provides nursing facility care in accordance with 42 CFR Part 483, Subpart B and which has 1 - 60 beds certified for Title XIX.

Private Nursing Facility for the Severely Disabled - A classification of long term care facilities which provides specialized nursing facility care to severely disabled residents, including, but not limited to, those with spinal cord injuries, closed head injuries, and ventilator-dependence, in accordance with 42 CFR, Part 483, Subpart B and MS Code 43-13-117 (44).