Table of Contents

State/Territory Name: AR

State Plan Amendment (SPA) #: 22-0013

This file contains the following documents in the order listed:

1) Approval Letter
2) CMS 179 Form/Summary Form (with 179-like data)
3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-14-28
Baltimore, Maryland 21244-1850

Financial Management Group

August 2, 2022

Dawn Stehle
Deputy Director for Health and Medicaid Director
Arkansas Department of Human Services
112 West 8th Street, Slot S401
Little Rock, AR 72201-4608

RE: TN 22-0013
Dear Ms. Stehle:

We have reviewed the proposed Arkansas State Plan Amendment (SPA) to Attachment 4.19-D, AR 22-0013, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on May 11, 2022. The intent of this amendment is to allow the Arkansas Department of Human Services to amend their Long Term Care reimbursement manual to update its payment methodology for skilled nursing facilities. These revisions were necessary due to changes in the skilled nursing facility standards over the past several years.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. Based upon the information provided by the State, we have approved the amendment with an effective date of August 1, 2022. We are enclosing the approved CMS-179 and a copy of the new state plan page.

If you have any additional questions or need further assistance, please contact Douglas Spitler at douglas.spitler@cms.hhs.gov.

Sincerely,

[redacted]

Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER	2. STATE
22-0013	AR

3. PROGRAM IDENTIFICATION: TITLE OF THE SOCIAL SECURITY ACT — (●) XIX ( ) XXI

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
8-1-2022

5. FEDERAL STATUTE/REGULATION CITATION
1902 of the Social Security Act

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 7,162,000
b. FFY 2023 $ 42,972,000

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
See Attached.

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
See Attached.

9. SUBJECT OF AMENDMENT
Manual of Cost Reimbursement Rules for Long Term Care Facilities (LTCF)

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Elizabeth Pitman

13. TITLE
Director, Division of Medical Services

14. DATE SUBMITTED
05/11/2022

15. RETURN TO
Office of Rules Promulgation
PO Box 1437, Slot S295
Little Rock, AR 72203-1437

Attn: Mac Golden

FOR CMS USE ONLY

16. DATE RECEIVED
5/11/2022

17. DATE APPROVED
August 2, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
08/1/2022

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, Financial Management Group

22. REMARKS

ATTACHED LISTING FOR
ARKANSAS STATE PLAN
TRANSMITTAL #2022-0013
Manual of Cost Reimbursement Rules for LTCF

7. Number of the Plan Section or Attachment	8. Number of the Superseded Plan Section or Attachment
Title Page	Title Page Approved 07-28-99, TN 99-0099
Introduction	Introduction Approved 07-28-99, TN 99-0099
Page 1-3	Page 1-3 Approved 04-04-17, TN 16-0017
Page 1-4	Page 1-4 Approved 07-28-99, TN 99-0099
Page 2-2	Page 2-2 Approved 04-04-17, TN 16-0017
Page 2-2a	Page 2-2a Approved 09-14-04, TN 04-0016
	Page 2-2aa Removed
Page 2-2b	Page 2-2b Approved 04-24-01, TN 01-0005
Page 2-2bb	Page 2-2bb New Page
Page 2-2bbb	Page 2-2bbb New Page
Page 2-2c	Page 2-2c Approved 04-04-17, TN 16-0017
Page 2-2ff	Page 2-2ff Approved 04-04-17, TN 16-0017
Page 2-2fff	Page 2-2fff Approved 04-04-17, TN 16-0017

Page 2-2g	Page 2-2g Approved 04-24-01, TN 01-0005
Page 2-2k	Page 2-2k Approved 09-24-09, TN 09-0014
Page 3-3	Page 3-3 Approved 07-28-99, TN 99-0099
Page 3-3a	Page 3-3a New Page
Page 3-5	Page 3-5 Approved 07-28-99, TN 99-0099
Page 3-11a	Page 3-11a Approved 08-17-04, TN 04-0014

DEPARTMENT OF HUMAN SERVICES

Medical Assistance Program
Manual Of Cost Reimbursement Rules
For
Long Term Care Facilities

(July 1, 1999)
(Last Revised 08/01/2022)

Introduction

This manual is for use by providers, their accountants and the Department of Human Services in determining the allowable and reasonable cost of Long Term Care services furnished to Medicaid recipients. The manual contains procedures to be used by each provider in accounting for its operations and in reporting the cost of care and services to the Department of Human Services.

The Long Term Care Program is administered by the Division of Medical Services. The program herein adopted is in accordance with Federal Statute in the Social Security Act § 1902 (a) (13) (A) and Public Law 105-33. The applicable Federal Regulations begin at 42 Code of Federal Regulations § 430. Each Long Term Care Facility which has contractually agreed to participate in the Title XIX Program will adopt the procedures set forth in this manual and must file the required cost reports.

As interpretations and changes of this program are made, appropriate revisions of the manual will be furnished to each provider and interested party. Care should be taken to insure that revisions to the manual are promptly inserted.

Questions relating to this program or relating to the interpretation of any of the provisions included in this manual should be addressed to:

Department of Human Services
Division of Medical Services
P. O. Box 1437, Slot **S535**
Little Rock, AR 72203-1437

opening or acquisition, then the reporting period shall begin at official certification date rather than the date of acquisition. Nursing Facilities that are newly purchased or leased shall submit a cost report for the period beginning with their first day of operation through the end the State Fiscal Year unless the cost reporting period would be less than three months of operation. Facilities that change ownership after April 1 of a State Fiscal Year would not submit a cost report from the date of initial operation to the end of the State Fiscal Year. Facilities changing ownership after April 1 of a State Fiscal Year will prepare and submit a cost report for the period beginning their first day of operation through the end of the month which includes their sixth month of operation.

A. When To File

Nursing facilities will report cost on a fiscal year ending June 30. Cost reports will be due within **ninety (90)** days after the end of the reporting period. Under **sixteen (**16**)** Bed ICF/IID providers will report cost on a calendar year basis. The cost report will be due within **ninety (**90**)** days of the end of the reporting period. The Arkansas Health Center Nursing Facility and the **sixteen (**16**) bed** and over ICF/IID providers will report cost semi-annually (January 1 - June 30) and (July 1 - December 31) with the cost reports being due **within sixty (60) days of the end of the reporting period**. Should the due date fall on a Saturday, Sunday, or State of Arkansas holiday or federal holiday, the due date shall be the following business day. **Nursing Facility cost r**eports are to be **electronically submitted through the LTC cost report web application** on or before the applicable due date. **ICF/IID reports are to be delivered, postmarked or electronically uploaded, to the web portal on or before the applicable due date.**

Providers who fail to submit cost reports and other required schedules and information by the due date or extended due date have committed a Class D Violation of Arkansas Code 20-10-205. Civil penalties associated with failure to timely submit a cost report for Long Term Care Facilities are detailed in Section 1-11 of this Manual.

B. Extensions for Filing

If a written request for an extension is received by the **Division of Medical Services** in advance of the report due date and a written extension is granted, a penalty will not be applied, provided the extended due date is met. Each request for extension will be considered on its merit. No extension will be granted unless the facility provides written evidence of extenuating circumstances beyond its control, which causes a late report. In no instance will an extension be granted for more than **thirty (**30**)** days.

C. What to Submit

In addition to the applicable cost report forms, providers must submit the following:

1. Most recently completed Medicare Cost Report,

2. Working trial balance and related working papers identifying the cost report line each account is included on,

3. Detailed depreciation schedule,

4. Any work papers used to compute adjustments made on the cost report,

5. A copy of any new or amended contracts for management services by a related party, home office or a third party which includes the basis used to allocate the costs to providers of the group and to non-provider activities, if applicable.

6. Copy of new or amended lease agreement if a leased facility.

When it is determined, upon initial review for completeness by the **Division of Medical Services**, that a cost report has been submitted without all required 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 by an extended 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, the cost report will be subject to the penalty provisions for delinquent submission. An exception exists in the event that the due date (or extended due date when an extension has been granted) 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 (or extended due date if an extension has been granted) of the cost report.

D. Where to Submit

Nursing facility cost reports and additional information should be submitted through the LTC cost report web application. ICF/IID cost reports and additional information may be submitted to the address below or uploaded to the contractor's web portal.

Arkansas Department of Human Services
Division of Medical Services
P. O. Box 1437 - Slot **S535**
Little Rock, AR 72203-1437

E. Amended Cost Reports

Providers can submit amended cost reports to the Department up to **one hundred, eighty (**180**)** days after the close of the cost reporting period.

A. Nursing Facilities

1. Reimbursement Methodology

Reimbursement rates for nursing facilities will be cost-based, facility-specific rates that will consist of four **(4)** major cost components and will be determined in the following way.

Reimbursement rates will be determined by adding calculated per diem amounts for four **(4)** separate components of cost: Direct Care, Indirect, Administrative and Operating, Fair Market Rental, and the Quality Assurance Fee. This cost data for calculating these per diems will be taken from desk reviewed cost reports submitted by providers in accordance with these regulations. Only full-year cost reports will be used in establishing cost ceilings and class rates. Cost reports that are submitted because of changes of ownership, whether via purchase or lease, will be used for calculating the facility's individual rate components but will not be used in calculating the direct care ceiling or the indirect, administrative, and operating class rate. The methodology for calculating the per diem amounts for each component of cost is provided below:

A. Direct Care

Direct care per diem cost shall be calculated from the facility's actual allowable Medicaid cost as reported on the facility's cost report. The direct care per diem cost is subject to a ceiling.

The ceiling shall be established at **one hundred five percent (**105%**)** of the allowable Medicaid direct care cost per diem incurred by the facility at the **ninetieth (**90^{th}**)** percentile of arrayed Medicaid direct care facility cost.

The direct care component of the rate will rebase annually for the period July 1st to June 30th. An inflation index **(see Section A. 6.)** will be applied to the provider's direct care per diem cost to inflate cost from the cost reporting period to the rate period.

B. Indirect, Administrative, and Operating

The per diem payment for this component will be set at **one hundred ten percent (**110%**)** of the median indirect, administrative, and operating per diem cost adjusted for inflation using the inflation index (see Section A. **6**.) and paid as a class rate to all facilities. This per diem payment will be rebased **annually**.

C. Fair Market Rental

A fair rental system will be used to reimburse property costs. The fair rental system reduces the wide disparity in the cost of property payments for basically the same service therefore making this payment fairer to all participants in the program. The fair market rental system will be used in lieu of actual cost and/or lease payments on land, buildings, fixed equipment, and major movable equipment used in providing resident care. The fair rental payment for facilities that are leased from a related party will be calculated from the costs associated with the related party in conformity with related party regulations.

The payment for provider property cost will be calculated annually by adding the return on equity, facility rental factor, and the cost of ownership, and dividing the sum of these three components by the greater of the actual resident days or resident days calculated at the following occupancy levels. **The minimum occupancy percentage for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year shall be sixty percent (60%). Thereafter, the minimum occupancy percentage shall increase as indicted in the following table, up to a maximum of seventy-five percent (75%).**

Cost Report Period	Rate Period	% Occupancy
SFY 2022	**SFY 2023**	**60%**
SFY 2023	**SFY 2024**	**65%**
SFY 2024	**SFY 2025**	**70%**
SFY 2025	**SFY 2026**	**70%**
SFY 2026 & after	**SFY 2027 & after**	**75%**

Resident days at the minimum occupancy level are calculated as: *Total Licensed Beds x Number of Days in the Period x Minimum Occupancy Percentage.*

1. Return on Equity

The return on equity portion of the fair market rental payment will be calculated by taking the Current Asset Value (CAV) of a facility less the ending loan balance on any loans used to finance fixed assets or major movable equipment, times the sum of the **average Moody's Seasoned Baa Corporate Bond Yield for the month of June in the applicable cost reporting period** plus **one and a half percent (**1.5%**)** as a risk premium. For purposes of calculating return on equity and determining allowable interest expense, allowable debt cannot exceed the facilities Current Asset Value. The maximum rate used for calculating return on equity will be **ten percent (**10%**)**.

The Current Asset Value (CAV) of a facility is calculated by multiplying the number of beds in a facility by the Per Bed Valuation (PBV) less an aging index of **one percent (**1%**)** for each year of age, not to exceed a **fifty percent (**50%**)** reduction in PBV. A facility will be considered new the cost reporting period in which the facility is licensed. A facility will be considered one year old the following cost reporting period. The CAV of a facility will be recalculated and an appropriate adjustment to the per diem will be made when additional beds are placed in operation.

Beginning with the CY 2023 rate year and based on the Base PBV for the SFY cost reporting period, the PBV methodology shall differentially apply PBV amounts according to the class of resident room where a licensed bed is located.

Class A Resident Room	
Criteria for Class A Room	**PBV Applicable to Each Licensed Bed in a Class A Room**
A private, single occupancy resident bedroom. Maximum of one licensed bed per room. Each Class A private room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private resident room. A Class A room must meet minimum space and other standards for private rooms and attached private bathrooms as set in Department regulations for a licensed SNF.	Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is $196,977. Updated annually as Base PBV is updated for increases in the construction index.
Class B Resident Room	
Criteria for Class B Room	**PBV Applicable to Each Licensed Bed in a Class B Room**
A semi-private, double occupancy resident bedroom. Maximum of two licensed beds per Class B room. Each Class B room shall have an attached private bathroom, or an attached private bathroom shared with one adjoining private or semi-private resident room. A Class B room must meet minimum space and other standards for semi-private rooms and attached private bathrooms as set in Department regulations for a licensed SNF.	Base PBV (full PBV) for the SFY 2022 cost reporting period and applicable to the CY 2023 rate year is $140,594. Updated annually as Base PBV is updated for increases in the construction index.

Class C Resident Room	
Criteria for Class C Room	**PBV Applicable to Each Licensed Bed in a Class C Room**
A Class C room is any resident room that does not meet the criteria for a Class A room or Class B room. Maximum of two licensed beds per Class C room. For example, a Class C room includes any private or semi-private room lacking an attached private bathroom or where the occupants otherwise must rely on a communal bathroom(s) for toileting.	Fixed at the Per Bed Value in effect on June 30, 2022, with no annual update thereafter for the construction index.

The PBV will be adjusted annually thereafter to reflect changes in construction costs as indicated per the **Core Logic** Marshall **& Swift** Valuation Service. A percentage increase will be calculated by dividing the difference between the Comparative Cost Multipliers construction index for Little Rock, Arkansas, for the quarter ending January of the cost reporting period and January of the previous year. The annual adjustment percentage will be the lessor of the percentage as calculated above for building classes:1) Masonry Bearing Walls, 2) Wood Frame, or **five percent (5%)**.

Every five (5) years, the Division shall analyze and compare the annual updates made using the construction cost index and the actual total cost (including physical plant, fixed equipment, land acquisitions and land improvements) of new SNF construction in Arkansas during the same period. The Division shall rebase the base PBV if actual construction costs increased more than estimated by the construction index.

2. Facility Rental Factor

A facility rental factor will be paid for each facility. The rental factor is calculated by multiplying the CAV of the facility by **two and a half percent (**2.5%**)**.

3. Cost of Ownership

   The cost of ownership component of the property payment will consist of interest, property taxes, and insurance premiums (including professional liability and property) as identified on the facility's cost report. The limitation on allowable interest expense is addressed in the return on equity calculation described above. The limitation on allowable professional liability insurance is addressed in Section 3-2 J. 9.

4. Minor Equipment Purchases

   The cost of purchases of minor equipment is not covered in the Fair Market Rental Payment. Minor equipment for the purposes of reimbursement is any equipment that has a unit cost of **less than two thousand five hundred dollars ($2,500).** Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used **(i.e., direct care cost component or indirect, administrative, and operating component)**.

5. Renovations

   The current asset value of a facility will be adjusted as a result of major renovations made to an existing facility. A major renovation is defined as renovations made to a facility where the total per bed cost of the renovation equals or exceeds ten percent (10 %) of the facility's current per bed value for the beds renovated or five (5%) for renovations to common areas. The actual cost of all additions or fundamental alterations to a facility that are required by state or federal laws or rules that take effect during the cost reporting period will be treated as an adjustment to the provider's aging index regardless of the percentage of current per bed value. The cost of renovation will be treated as an adjustment to the provider's aging index. A facility's aging index will be reduced by one percent (1%) for each percent of the current per bed value expended for renovations on a per bed basis. For facilities that have beds that have been placed in operation at different times or when renovations include only a portion of the beds in a facility, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will relate to only those beds that were included in the renovation. For renovations to common areas, the determination that the renovation meets the criteria of major renovation and the reduction of the aging index will be applied proportionally to all beds.

4. Rates for Facilities that Change of Ownership

   Facilities that have a change in licensure due to purchase or lease of an existing facility participating in the Medicaid program will be **reimbursed the previous operator's rate as of the date of the change of ownership. When this rate extends from one rate period to another, an inflation index will be applied to the per diem rate to establish the rate for the new rate period. The inflation factor to be used is addressed in Section 2-4 A. 6.**

5. Terminating Facilities

   Facilities that withdraw from the Medicaid program either voluntarily or involuntarily will not be required to submit a final cost report. All payments made to a facility as interim or provisional will be considered as final. This provision does not apply to any fines or penalties that have been imposed on a facility.

6. Inflation Index

   For all inflation adjustments (unless stated otherwise in the specific area of the plan) the Department will use the Skilled Nursing Facility Market Basket **Index as published by the Centers for Medicare and Medicaid Services. The Department will use the Four Quarter Moving Average Percent Change identified for the final quarter of the rate period.**

7. Adjustments to Provider Cost Reports

   Adjustments to an individual provider's per diem may be necessary as a result of amended cost reports, desk review, or audit. Should a provider's per diem be adjusted for any reason a retroactive adjustment will be made for all resident days paid back to the beginning of the rate period. Adjustments to a provider's per diem resulting from any source other than

an inquiry for additional information as a result of a desk review for **which provided** within required deadlines will only affect the per diem for that particular provider. Cost component ceilings for applicable cost components and the floor established for direct care will not be adjusted under these circumstances.

8. Cost Components:

For rate setting, facility allowable costs from desk reviewed facility cost reports for an annual period ending June 30, will be identified and grouped as: Direct Care; Indirect, Administrative, & Operating; Property Costs (Identified for informational purposes, the reimbursement rate for property costs will be determined by the Fair Market Rental method as outlined above in Item A. 1. C.); and Quality Assurance Fee.

a. Direct Care Expenses

The following expenses are classified as Direct Care.

Salaries-Aides
Salaries-Medication Assistants
Salaries-LPN's
Salaries-RNs
Salaries-Occupational Therapists
Salaries-Physical Therapists
Salaries-Speech Therapists
Salaries-Other Therapists
Salaries-Rehabilitation Nurse Aide
Salaries-Assistant Director of Nursing
Salaries-Director of Nursing
FICA-Direct Care
Group Health-Direct Care
Pensions-Direct Care
Unemployment Taxes-Direct Care
Uniform Allowance-Direct Care
Worker's Compensation-Direct Care
Other Fringe Benefits-Direct Care
Contract-Aides
Contract-Medication Assistants
Contract-LPN's
Contract-RN's
Training-Direct Care
Drugs, Over-the-Counter
Oxygen
Medical Supplies-Direct Care
Contract-Occupational Therapists
Contract-Physical Therapists

Contract-Speech Therapists

TN: 22-0013 Approval Date: August 2, 2022 Effective Date: 8/1/22
Supersedes TN: 01-005

9. Home Style Facilities

A. Fair Market Rental Payment

Minimum occupancy rules **(as defined in Section 2-4 A. 1. C.)** for calculating the facility fair market rental payment will be calculated and applied separately for beds certified as Home Style. All other policy described in this Cost Manual regarding the calculation of a facility's fair market rental payment is applicable to Home Style Facility beds.

All costs associated with renovating or constructing beds for initial certification as Home Style shall not be considered a renovation as detailed in section 2-4, A. 1. C. 5. of this Cost Manual. Thereafter, Home Style beds are eligible for renovation adjustment as detailed in the Cost Manual.

A nursing facility participating in this program may certify less than **one hundred percent (**100%**)** of its beds as Home Style Facility beds. A facility may have a combination of traditional style nursing facility beds and Home Style Facility beds within a single licensed facility.

B. Cost Reporting

A facility or any part thereof, certified by the Office of Long Term Care as Home Style shall prepare and submit a Financial and Statistical Report/Cost Report. The cost report for Home Style beds will be identified as such by including the words Home Style at the end of the facility name **wherever** used. The cost report must be prepared in accordance with all reimbursement rules and reporting requirements detailed in **the** "Manual of Cost Reimbursement Rules." Combination facilities will be required to complete a separate cost report for both the traditional beds and beds certified as Home Style Facility beds. Whenever possible, costs that can be directly identified to either the traditional or Home Style beds must be included on the appropriate cost report. The department recognizes that certain costs **cannot** be directly identified and benefit both reporting entities. These shared costs

(2) to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident.

c) Normal conduct of operations relating to recipient care refers to otherwise allowable costs that include, but are not limited to, the following:

(1) expenses for facilities, materials, supplies, or services used by a facility solely for providing longterm recipient care. Whenever otherwise allowable costs are attributable partially to personal or other business interests and partially to facility recipient care, the latter portion may be allowed on a pro rata basis if the basis for allocation of expense for recipient care purposes is well-documented. This documentation includes the allocation methodology and appropriate logs necessary to support amount attributed to recipient care;

(2) allowable costs which result from arms-length transactions involving unrelated parties. In transactions involving related organizations, the allowable cost to the facility is the cost to the related party. Allowable costs in this regard are limited to the lesser of the actual purchase price to the related party, or usual and customary charges for comparable goods or services.

d) Allowable costs must be reported net of any applicable returns, allowances, discounts, and refunds.

2. Costs of Related Organizations — Costs for services or supplies furnished to the facility by related organizations are allowable at the cost to the related party to the extent that they are reasonable and necessary in the normal conduct of operations relating to recipient care in a facility and **do not exceed** those costs incurred by a prudent buyer. **Providers should treat the cost incurred by the related party as if they were incurred by the provider itself. Providers must supply a detail income statement from the related party entity so the proper cost report classification can be determined. If the cost to the related party would be classified as a direct care cost by the nursing facility, then the related cost must be claimed on a direct care line on the cost report. If the cost to related party would be classified as an indirect, administrative, and operating cost by the nursing facility, then the related party cost must be claimed on an indirect, administrative, and operating cost report line. If the cost to related party would be classified as a property cost by the**

nursing facility, then the related party cost must be claimed on a property cost report line. Expenses for transactions with related

TN: 22-0013
Supersedes TN: 99-009
Approval Date: August 2, 2022
Effective Date: 8/1/22

organizations should not exceed expenses for like items in arms' length transactions with other non-related organizations.

a) Related Organization — A related organization (includes individuals, partnerships, corporations, etc.) is one where the provider is associated or affiliated with, has common ownership, control, or common board members, or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

f) The facility must furnish to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies, services, or facilities furnished to the facility. Such documentation must include an identification of the organization's total costs, and the basis for allocating direct and indirect costs to the facility and to other entities served.

g) Limitations on cost for related party transactions will not apply to the sale of one or more nursing facilities by a person to that person's child or children for money equal to the fair market value of the facility or facilities. All other regulations relating to the sale of a facility will apply.

3. Unallowable Costs — Those expenses that are not reasonable or necessary for the provision of recipient care in a facility, according to the criteria as specified in paragraph (1) of the subsection. Unallowable costs are not included in the rate base used for determining reimbursement rates.

4. Prudent Buyer Concept - Allowable costs may not exceed the cost that a prudent buyer would pay in the open market to obtain products or services.

5. Arms-Length Transaction - A voluntary transaction between a knowledgeable and willing buyer unrelated to the seller, with each acting for his or her own independent self-interest.

3-2 List of Allowable Costs

The following list of allowable costs is not all **inclusive but** serves as 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. As discussed further in Section 3-4, certain income items will reduce allowable costs and be offset against the appropriate line items for salaries and wages or other service expenses. Except where specific exceptions are noted, the allowability of all costs is subject to the amounts being reasonable and to the other general principles specified in section 3-1 of this chapter.

A. Compensation of facility employees. This includes compensation for only those employees who provide services directly to the recipients or staff of individual facilities in the normal conduct of operations relating to recipient care: certified nurse aides; nurse aides in training; **medication assistants;** licensed practical nurses; graduate practical nurses; registered nurses; graduate nurses; other salaried direct care staff; occupational therapists; physical therapists; speech therapists; other therapists; activities
personnel; assistant director of nursing; director of nursing; pharmacy personnel; social services personnel; administrator; assistant administrator; food service

TN: 22-0013 Approval Date: August 2, 2022 Effective Date: 8/1/22
Supersedes TN: 99-009

personnel; housekeeping, laundry, and maintenance staff; medical records personnel; other administrative staff; accounting staff; and data processing

a) Generally accepted accounting principles incorporating the straight-line method of depreciation must be used. Accelerated methods of depreciation are not acceptable. Facilities must follow American Hospital Association Guidelines for Depreciation as the basis for calculation of straight-line depreciation. Capitalization is not required for minor equipment costing less than **two thousand five hundred dollars ($2,500) per item**. **Minor equipment purchases are to be expensed in the cost area in which the equipment is normally used (i.e., direct care cost component or indirect, administrative, and operating component).** It is not required to deduct salvage value from the cost of the asset for the purpose of calculating depreciation. Component depreciation for physical structures is not acceptable.

Depreciation expense for the year of acquisition and the year of disposal can be computed by using: (1) the half-year method; or (2) the actual time method.

b) The method and procedure for computing depreciation must be applied from year-to-year on a consistent basis.

c) The assets shall be recorded at cost. Cost during the construction of an asset, such as architectural, consulting, and legal fees, interest, etc., must be capitalized as a part of the cost of the assets. When an asset is acquired by trade in, the cost of the new asset is the sum of the book value of the old asset and any cash or issuance of debt