

**Title 13—DEPARTMENT OF
SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 10—Nursing Home Program**

PROPOSED AMENDMENT

Editing Notes: Language in *[brackets and italics will be deleted]*
Language in **bold print will be added**

13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services. The division is amending the Purpose and sections (3), (4), (5), (6), (7), (8), (9), (10), (14), and (17), and adding section (22).

PURPOSE: This amendment removes or replaces obsolete processes, language, and terms; clarifies regulation language; allows an extension for cost report filings for good cause shown; amends when cost reports are required for terminating providers or changes in providers; amends when payments will be withheld for late cost report submissions and terminating providers; establishes a required prior authorization process for any out-of-state nursing facility to be reimbursed for nursing facility services; and, revises the methodology for determining prospective rates.

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

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

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

(3) General Principles.

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

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

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

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible [*recipient's*] **participant's** covered days of care, within benefit limitations as determined in subsections (5)(D) and (M) multiplied by the facility's Medicaid reimbursement rate. No payments may be collected or retained in addition to the Medicaid reimbursement rate for covered services, unless otherwise provided for in this [*plan*] **regulation**. Where third-party payment is involved, Medicaid will be the [*payor*] **payer** of last resort with the exception of state programs such as vocational rehabilitation and the Missouri Crippled Children's Services.

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

1. The Medicare (Title XVIII) rate, if applicable; or
2. The reimbursement rate as determined in accordance with this regulation.

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

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

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

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

(J) Changes in ownership, management, control, operation, leasehold interest by whatever form for any facility previously certified for participation in the Medicaid Program at any time that results in increased capital costs for the successor owner, management, or leaseholder shall not be recognized for purposes of reimbursement [*and etc*].

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

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

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

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

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

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

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

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

[(S) Each state fiscal year the department shall submit to the Office of Administration for consideration a budget item based on the HCFA Market Basket Index for Nursing Homes representing a statistical measure of the change in costs of goods and services purchased by nursing facilities during the course of one (1) year. The submission of the budget item by the department has no correlation to determining the costs that are incurred by an efficiently and economically operated facility. Any trend factor granted shall be applied to the patient care, ancillary and administration cost components, and the pass-through expenses included in the capital cost component per diem. For facilities with allowable costs from their 1992 desk audited and/or field audited cost report as determined in this regulation that are below the facilities' January 1, 1994 reimbursement rate, any granted trend factor shall be limited to the product of the new plan rate divided by the January 1, 1994, (old plan rate) times the facility's trend factor. For example:

<i>New Plan Rate (1-1-95)</i>	<i>\$49.19</i>
<i>January 1, 1994 Rate</i>	<i>\$54.32</i>
<i>Proposed Trend Factor</i>	<i>\$ 1.88</i>
<i>Adjusted Trend Factor</i>	<i>\$ 1.70</i>

$$\begin{aligned} &(\$49.19/\$54.32) * \$1.88 \\ &90.55\% * \$1.88 = \$1.70 \end{aligned}$$

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

[(T)] (S) Rebasing.

1. The division based on its discretion shall pick at least one (1) cost report year from cost reports with fiscal years ending in 2001 or later to compare the allowable costs from the selected desk audited and/or field audited cost report year to the reimbursement rate in effect at the time of the comparison. The rebased rates shall be determined in accordance with section(s) (20)-(21), as applicable.

2. The asset value will be adjusted annually based on the R. S. Means Construction Index. The asset value as adjusted will be used only for determining reimbursement in section (11) for the year(s) selected above for rebasing and as determined in paragraphs (13)(B)6. and (13)(B)7. ~~[(U)]~~ **(S)** Effective for dates of service beginning April 1, 2010, reimbursement of Medicare/Medicaid crossover claims (crossover claims) for Medicare Part A and Medicare Advantage/Part C inpatient skilled nursing facility benefits shall be as follows:

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

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

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

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

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

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

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

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

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

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

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

3. MO HealthNet reimbursement will be the lower of—

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

B. The coinsurance amount; and

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

(4) Definitions.

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

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

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

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

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

(D) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this regulation. The allowability of costs shall be determined by the *[Division of Medical Services]* **MO HealthNet Division** and shall be based upon criteria and principles included in this regulation, the *Medicare Provider Reimbursement Manual* (HIM-15) and GAAP. Criteria and principles will be applied using this regulation as the first source, the *Medicare Provider Reimbursement Manual* (HIM-15) as the second source and GAAP as the third source.

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

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

2. Version MSIR-1 (3-95): lines 71–101.

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

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

1. Level I Audit - Requires a more narrow scope of review of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The limited review may include items such as a comparative analysis of a provider's cost report data to industry data or a review of a provider's prior year data to determine any outliers that may warrant further review, which could lead to potential adjustment(s) after such further review, make any standard adjustments, etc. Level I audits may be provided off-site.

2. Level II Audit - Requires a desk review of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The desk review may include review procedures in a Level I Audit plus a more detailed analysis of a provider's cost report data to identify items that would require further review including requesting additional details of the reported information, documentation to support amounts reflected in the cost report, etc. Level II audits may be provided off-site.

3. Level III Audit – Requires an in depth audit, including an on-site review, of provider cost reports, files and any other additional information requested and submitted to the MO HealthNet Division or its authorized contractor. The Level III Audit will require an in depth analysis of a provider's cost report data and an on-site verification of cost report items deemed necessary through a risk assessment or other analyses, etc. Level III audits will require some portions of the provider's records review be provided on-site.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[(HH)] **(GG)** Interim rate. The interim rate is the sum of one hundred percent (100%) of the patient care cost component ceiling, ninety percent (90%) of the ancillary and administration cost component ceilings, ninety-five percent (95%) of the median per diem for the capital cost component, and the working capital allowance using the interim rate cost component. The median per diem for capital will be determined from the capital component per diems of providers with prospective rates in effect on January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward.

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

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

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

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

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

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

1. Version MSIR-1 (7-93): lines 45–60, 77–85; and
2. Version MSIR-1 (3-95): lines 46–70.

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

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

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

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

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

[(TT)] (SS) Reimbursement rate. A prospective or interim rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Semiprivate room and board;

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

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

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

(F) All laundry services, including personal laundry;

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

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

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

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

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

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

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

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

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

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

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

(7) Allowable Cost Areas.

(A) Compensation of Owners.

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

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

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

(C) Capital Assets.

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

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

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

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

1. Depreciation.

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

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

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

- (I) The book value of the provider;
- (II) Fair market value at the time of acquisition; or
- (III) The recognized Internal Revenue Service (IRS) tax basis.

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

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

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

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

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

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

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

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

(E) Insurance.

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

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

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

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

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

2. Loans (including finance charges, prepaid costs, and discounts) must be supported by evidence of a written agreement that funds were borrowed and repayment of the funds are required. The loan costs must be identifiable in the provider's accounting records, must be related to the reporting period in which the costs are claimed, and must be necessary for the acquisition and/or renovation of the provider's facility.3. Necessary means that the loan be incurred to satisfy a financial need of the provider and for a purpose related to [recipient] **participant** care. Loans which result in excess funds or investments are not considered necessary.

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

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

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

(G) Rental and Leases.

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

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

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

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

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

(I) Value of Services of Employees.

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

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

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

(J) Employee Benefits.

1. Retirement plans.

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

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

2. Deferred compensation plans.

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

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

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

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

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

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

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

(K) Education and Training Expenses.

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

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

(L) Organizational Costs.

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

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

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

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

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

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

(O) Minimum Utilization. In the event the occupancy rate of a facility is below eighty-five percent (85%), the administration and capital cost components will be adjusted as though the provider experienced eighty-five percent (85%) occupancy. The adjustment for minimum utilization is reflected in the calculation of the per diem for the administration and capital cost components. If the provider's occupancy is less than eighty-five percent (85%), the total allowable costs are divided by the minimum utilization days rather than the facility's actual patient days. Minimum utilization days are calculated by multiplying the facility's bed days by the minimum utilization percent. Bed days are calculated by multiplying the number of beds licensed during the cost report period times the days in the cost report period. If the facility is removing the noncertified area revenues and expenses by completing a worksheet 1, bed days are calculated by multiplying the number of beds certified during the cost report period times the days in the cost report period. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Central Office/Home Office or Management Company Costs. The allowability of the individual cost items contained within central office/home office or management company costs will be determined in accordance with all other provisions of this regulation. The total of central office/home office and/or management company costs, as reported on lines 129 and 130 of the cost report, version MSIR (7-93) and lines 121 and 122 of CR (3-95), are limited to seven percent (7%) of gross revenues less contractual allowances.

(Q) Start-Up Costs. Expenses incurred prior to opening, as defined in HIM-15 as start-up costs, shall be amortized on a straight-line method over sixty (60) months. The amortization shall be reported on the same line on the cost report as the original start-up costs are reported. For example, RN salary prior to opening would be amortized over sixty (60) months and would be reported on line 49, RN of CR (7-93) and line 51 of CR (3-95).

(R) Reusable Items. Costs incurred for items, such as linen and bedding, but not limited to, shall be classified as inventory when purchased and expensed as the item is used.

(S) Nursing Facility Reimbursement Allowance (NFRA). Effective October 1, 1996, the fee assessed to nursing facilities in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Non-allowable Costs. Costs not reasonably related to nursing facility services shall not be included in a provider's costs. Non-allowable costs include, but are not limited to, the following:

(A) Amortization on intangible assets, such as goodwill, leasehold rights, covenants, and purchased certificates of need;

(B) Bad debts, contractual allowances, courtesy discounts, charity allowances, and similar adjustments or allowances are offsets to revenues and, therefore, not included in allowable costs;

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

(D) Charitable contributions;

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

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

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

(H) Federal, state, or local income and excess profit taxes, including any interest and penalties paid thereon;

(I) Late charges and penalties;

(J) Finder's fees;

(K) Fund-raising expenses;

(L) Interest expense on loans for intangible assets;

(M) Legal fees related to litigation involving the department and attorney's fees which are not related to the provision of nursing facility services, such as litigation related to disputes between or among owners, operators, or administrators;

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

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

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

1. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. *[Owners/administrators]* **Owners acting as administrators** will be adjusted on the basis of the high range. Owners included in home office costs or management company costs will be adjusted on the high range. All others will be calculated on the median range.

2. The salary identified above will be apportioned on the basis of hours worked in the facility(ies), home office, or management company as applicable to total hours in the facility(ies), home office, or management company;

(Q) Prescription drugs;

(R) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers, or other similar types of professionals;

(S) Research costs;

(T) Resident personal purchases provided nonroutinely to residents for personal comfort or convenience;

(U) Salaries, wages, or fees paid to nonworking officers, employees, or consultants;

(V) Cost of stockholder meetings or stock proxy expenses;

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

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

(Y) All costs associated with nurse aide training and competency evaluation program; and

(Z) Losses from disposal of assets.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report. These revenues are offset against expenses. Such revenues include, but are not limited to, the following:

1. Income from telephone services;

2. Sale of employee and guest meals;
3. Sale of medical abstracts;
4. Sale of scrap and waste food or materials;
5. Cash, trade, quantity, time, and other discounts;
6. Purchase rebates and refunds;
7. Recovery on insured loss;
8. Parking lot revenues;
9. Vending machine commissions or profits;
10. Sales from supplies to individuals other than nursing facility *[recipients]* **participants**;
11. Room reservation charges other than covered therapeutic home leave days and hospital leave days;
12. Barber and beauty shop revenue;
13. Private room differential;
14. Medicare Part B revenues;
 - A. Revenues received from Part B charges through Medicare intermediaries will be offset;
 - B. Seventy-five percent (75%) of the revenues received from Part B charges through Medicare carriers will be offset;
15. Personal services;
16. Activity income; and
17. Revenue recorded for donated services and commodities.

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

(C) Restricted funds designated by the donor for capital expenditures will not be offset from allowable expenses.

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

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

(F) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies, will not be offset.

(G) Gains on disposal of assets will not be offset from allowable expenses.

(10) Provider Reporting and Record Keeping Requirements.

(A) Annual Cost Report. The cost report (version MSIR-1 (3-95)) and cost report instructions (revised 3/95) are incorporated by reference and made a part of this rule as published by the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109, August 1, 2008. This rule does not incorporate any subsequent amendments or additions.

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

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

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

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

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

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

7. Copies of signed agreements and other significant documents related to the provider's operation and provision of care to MO HealthNet participants must be attached (unless otherwise noted) to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted or available upon request includes, but is not limited to, the following:

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

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

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

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

F. Federal and state income tax returns for the fiscal year, if requested by the division, the department, or its *[agents]* **authorized contractor**;

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

H. Management contracts;

I. Medicare cost report, if applicable;

J. Review and compilation statement;

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

L. Working trial balance actually used to prepare the cost report with line number tracing notations or similar identifications; and

M. Schedule of capital assets with corresponding debt.

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

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

10. Exceptions. A cost report *[may]* **is** not *[be]* required for the following *[if a provider requests a waiver in writing. Upon review of the provider's request, the division shall provide a written response, indicating its decision as to whether a waiver shall be granted].*

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

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

[(I) Providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX participants, relative to their fiscal year, and have less than a twelve- (12-) month cost report due to a termination, change of ownership, or being newly MO HealthNet certified.

[(II) Beginning in SFY-04, the division may waive the cost report filing requirement for the cost report resulting from a change of control, ownership, or termination of participation in the MO HealthNet program if the old/terminating provider can show financial hardship in providing the cost report. The old/terminating provider must submit a written request to the division, indicating and providing documentation for the financial hardship caused by filing the cost report.

[(III) Beginning in SFY-07, the division may waive the cost report filing requirement for the cost report resulting from a change of control or ownership of participation in the MO HealthNet program if the old and new providers can provide assurances satisfactory to the division that the new providers will submit a cost report in the calendar year in which the change occurred and that the cost report will cover at least a three- (3-) month period. A written request jointly submitted by the old and new providers, indicating the new provider's fiscal year end and the dates that the cost report will cover, may provide adequate assurances.

11. *[Cost report requirements]* **Notification of change in provider status** and withholding of funds for a change in provider status. A provider shall provide written notification to the assistant deputy director of the Institutional Reimbursement Unit of the division prior to a change of control, ownership, or termination of participation in the MO HealthNet program. *[If a provider does not qualify for an exception for filing a cost report as detailed above in subparagraph (10)(A)10.C., the division may withhold payments due to the provider pending receipt of the required cost report. The cost report must be prepared in accordance with this regulation with all required attachments and documentation and is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of the fully completed cost report, any payments withheld will be released, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.]* **The division may withhold funds due to a change in provider status as follows:**

A. If the division receives notification prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division will withhold a minimum of thirty thousand dollars (\$30,000) of the remaining payments from the old/terminating provider. *[until the cost report is filed. Upon receipt of the cost report prepared in accordance with this regulation, any]* **After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.**

B. If the division does not receive notification prior to a change of control or ownership, the division will withhold thirty thousand dollars (\$30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement *[until the required cost report is filed]*. If the MO HealthNet payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. *[Upon receipt of the cost report prepared in accordance with this regulation, any]* **After six (6) months, any** payments withheld will be released to the provider identified in the current MO HealthNet participation agreement, less any amounts owed to the division such as unpaid NFRA, overpayments, etc.

[C. The division may, at its discretion, delay the withholding of funds specified in subparagraphs (10)(A)11.A. and B. until the cost report is due based on assurances satisfactory to the division that the cost report will be timely filed. A request jointly submitted by the old and new provider may provide adequate assurances. The new provider must accept responsibility for ensuring timely filing of the cost report and authorize the division to immediately withhold thirty thousand dollars (\$30,000) if the cost report is not timely filed.]

(B) Certification of Cost Reports.

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

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

3. The following statement must be signed on each cost report to certify its accuracy and validity: Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by (provider name and number) for the cost report period beginning (date/year) and ending (date/year), and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

(Signature)

(Title)

(Date)

(C) Adequate Records and Documentation.

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

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

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized *[agent]* **contractor** at the same site at which the services were provided or at the central office/home office if located in the state of Missouri. Copies of documentation and records shall be submitted to the division or its authorized *[agent]* **contractor** upon request.

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

(D) Audits.

1. Any cost report submitted may be subject to a **Level III Audit (also known as a field audit)** by the division or its authorized *[agent]* **contractor**.

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

3. If a provider maintains any records or documentation at a location which is not the same as the site where services were provided, other than central offices/home offices not located in the state of Missouri, the provider shall transfer the records to the same facility at which the Medicaid services were provided, or the provider must reimburse the division or its authorized *[agent]* **contractor** for reasonable travel costs necessary to perform any part of the field audit in any off-site location, if the location is acceptable to the division.

4. Those providers initially entering the program shall be required to have an annual independent audit of the financial records, used to prepare annual cost reports covering, at a minimum, the first two (2) full twelve- (12-) month fiscal years of their participation in the Medicaid Program, in accordance with GAAP and generally accepted auditing standards. The audit shall include, but may not be limited to, the Balance Sheet, Income Statement, Statement of Retained Earnings, and Statement of Cash Flow. For example, a provider begins participation in the Medicaid program in March and chooses a fiscal year of October 1 to September 30. The first cost report will cover March through September. That cost report may be audited at the option of the provider. The October 1 to September 30 cost report, the first full twelve- (12-) month fiscal year cost report, shall be audited. The next October 1 to September 30 cost report, the second full twelve- (12-) month cost report, shall be audited. **The audits shall be done by an independent certified public accountant. The independent audits of the first two (2) full twelve- (12-) month fiscal years may be performed at the same time. The provider may submit two (2) independent audit reports (i.e., one for each year) or they may submit one (1) combined independent audit report covering both years. The independent audit report(s) for combined audits are due with the filing of the second (2nd) full twelve- (12-) month cost report. If the independent audits are combined, the provider must notify the division of such by the due date of the first (1st) full twelve- (12-) month cost report.**

(E) Joint Use of Resources.

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

2. When the facility is owned, controlled or managed by an entity(ies) that owns, controls, or manages one (1) or more other facilities, records of central office and other costs incurred outside the facility shall be maintained so as to separately identify revenues and expenses of, and allocations to, individual facilities. Direct allocation of cost, such as RN consultant, which can be directly identifiable in the central office/home office cost and directly allocated to a facility by actual amounts or actual time spent. These direct costs shall be reported on the appropriate lines of the cost report. Allocation of central office/home office or management company costs to individual facilities should be consistent from year-to-year. If a desk audit or field audit establishes that records are not maintained so as to clearly identify information required by this regulation, those commingled costs shall not be recognized as allowable costs in determining the facility's Medicaid reimbursement rate. Allowability of these costs shall be determined in accordance with the provisions of this regulation.

(11) Cost Components and Per Diem Calculation. The division will use the rate setting cost report to determine the nursing facility's per diem rate for each cost component, as set forth in this section, and its prospective rate, as continued and set forth in the remaining sections of the regulation.

(A) Patient Care. Each nursing facility's patient care per diem shall be the lower of the—

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

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

(B) Ancillary. Each nursing facility's ancillary per diem will be the lower of the—

1. Allowable cost per patient day for ancillary as determined by the division from the rate setting cost report, including applicable trends; or

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

(C) Administration. Each nursing facility's administration per diem shall be the lower of the—

1. Allowable cost per patient day for administration as determined by the division from the rate setting cost report, including applicable trends, and adjusted for minimum utilization, if applicable, as described in subsection (7)(O); or

2. Per diem ceiling of one hundred ten percent (110%) of the administration median determined by the division from the data bank. The administration median shall be based on the administration per diems that have been adjusted for minimum utilization, if applicable, as described in subsection (7)(O).

(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which consists of five (5) elements—rental value, return, computed interest, borrowing costs, and pass-through expenses. The calculation for each element, as well as the overall capital per diem, is detailed below in paragraphs (11)(D)1.–6.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report.

(II) Determine the number of increased licensed beds after the end of the facility's 1992 desk audited and/or field audited cost report but prior to July 1, 1994 (this is only applicable for the 1992 initial rate base year for rates effective January 1, 1995).

(III) Determine the bed equivalency for renovations/major improvements from the date facility was originally licensed through June 30, 1994 for the 1992 initial rate base year for rates effective January 1, 1995 or through the end of the rate setting period for prospective rates effective after January 1, 1995, by taking the cost of the renovations/major improvements divided by the asset value per bed for the year of the renovation/major improvement rounded to the nearest whole bed. The cost of the renovation/major improvement must be at least the asset value per bed for the year of the renovation/major improvement for each bed equivalency. For example, a renovations/major improvements done in 1994 with a cost of two hundred twenty thousand dollars (\$220,000) is equal to six (6) beds. ($\$220,000/\$32,330$ equals 6.80 beds rounded down to 6 beds).

(IV) Determine the number of decreased licensed beds after the end of the facility's 1992 cost report but prior to July 1, 1994 (this is only applicable for the 1992 initial rate base year for rates effective January 1, 1995).

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

(VI) The Total Asset Value is the total facility size times the asset value.

B. Determine the reduction for age. The age of the beds is determined by subtracting the year the beds were originally licensed from the year relative to the end of the rate setting period. The reduction for age is determined by multiplying the age of the beds by one percent (1%) up to a maximum of forty percent (40%). For multiple licensing dates, the result of the weighted average age calculation will be limited to forty percent (40%).

(I) The age of the beds for multiple licensing dates is calculated on a weighted average method rounded to the nearest whole year. For example, using 1994 as the rate base year for a facility with original licensure in 1977 of sixty (60) beds and an additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1990, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1990	4	<u>10</u>	<u>40</u>
Total		130	1780

Weighted Average Age— $1780/130$ beds = 13.69 years rounded to 14 years. This results in a reduction for age of the beds of 14%.

(II) The age of the beds for replacement beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being replaced first. For example, a facility with one hundred twenty (120) beds licensed in 1978 with replacement of sixty (60) beds in 1988, the reduction is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1978	16	60	960
1988	6	<u>60</u>	<u>360</u>
Total		120	1320

Weighted Average Age— $1320/120 = 11.00$ years. This results in a reduction for age of the beds of 11%.

(III) The age of the beds for reductions in licensed beds is calculated on a weighted average method rounded to the nearest whole year with the oldest beds always being delicensed first. For example, a facility with original licensure in 1977 of sixty (60) beds, additional licensure of sixty (60) beds in 1982 and ten (10) beds in 1990 and a reduction of ten (10) beds in 1985, the reduction percentage is calculated as follows:

Licensure Year	Age	Beds	Age × Beds
1977	17	60	1020
1982	12	60	720
1990	4	10	40
1985*	17	<u>(10)</u>	<u>(170)</u>
Total		120	1610

* reduction of 1977 beds

Weighted Average Age— $1610/120$ beds = 13.41 years rounded to thirteen (13) years. This results in a reduction for age of the beds of 13%.

(IV) The age of the bed equivalents for renovations/major improvements is calculated on a weighted average method rounded to the nearest whole year. For example, a one hundred twenty (120) bed facility licensed in 1978 undertakes two (2) renovations: \$200,000 in 1983 and \$100,000 in 1993. The asset value per bed is \$25,250 for 1983 and \$32,039 for 1993. The bed equivalency is seven (7) beds for 1983 and three (3) beds for 1993, the reduction percentage is calculated as follows:

Licensure/ Construction	Year	Age	Beds	Age × Beds
	1978	16	120	1920
	1983	11	7	77
	1993	1	<u>3</u>	<u>3</u>
Total			130	2000

Weighted Average Method— $2000/130 = 15.38$ years rounded to 15 years. This results in a reduction for age of beds of 15%.

C. Determine the facility asset value. The facility asset value is the total asset value set forth in subparagraph (11)(D)1.A. less the reduction for age set forth in subparagraph (11)(D)1.B.

D. Determine the rental value. Multiply the facility asset value by two and one-half percent (2.5%) to determine the rental value. The two and one-half percent (2.5%) is based on a forty- (40-) year life.

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

(I) Assumptions:

1992 Rate Setting Cost Report

Licensed beds	170
Bed equivalents	4
Total facility size	174 beds
Weighted average age of the beds	23 years
Asset value	\$32,330

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

Total facility size	174
Asset value	× \$32,330
Total asset value	\$5,625,420

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

Total asset value	\$5,625,420
× Age of beds	× 23%
-Reduction for age (23%)	\$1,293,847
Facility asset value	\$4,331,573

(IV) Rental value is the facility asset value multiplied by 2.5%.

Facility asset value	\$4,331,573
	× 2.5%
Rental value	\$108,289

2. Return.

A. Reduce the facility asset value by the necessary outstanding capital asset debt from the rate setting cost report, but not less than zero (0), times the rate of return. The rate of return is the yield for the thirty- (30-) year Treasury Bond as reported by the Federal Reserve Board plus two percent (2%), as follows:

(I) For the initial 1992 rate base year for rates effective for dates of service from January 1, 1995 through June 30, 2004, the rate of return shall be set using the yield for the thirty- (30-) year Treasury Bond reported by the Federal Reserve Board and published in the *Wall Street Journal* for the week ending September 2, 1994, plus two percent (2%). The yield for the week ending September 2, 1994 is 7.48% plus 2% equals a total rate of return of 9.48%.

(II) For rates effective for dates of services beginning July 1, 2004, the rate of return is detailed in sections (20) and (21).

B. The debt associated with increases in licensed beds or renovations/major improvements after the end of the facility's 1992 desk audited and/or field audited cost report and prior to July 1, 1994, will be added to the capital asset debt from the 1992 desk audited and/or field audited cost report (this is only applicable for the 1992 initial rate base year for rates effective January 1, 1995). The facility shall provide adequate documentation to support the additional debt as required in paragraph (7)(F)2. If adequate documentation is not provided to support the additional asset debt, it will be assumed to equal the facility asset value.

C. The following is an illustration of how subparagraph (11)(D)2.A. is calculated:

Facility asset value	\$4,331,573
Capital asset debt	<u>\$2,371,094</u>
	\$1,960,479
Rate of return	<u>× 9.48%</u>
Return	\$ 185,853

3. Computed interest.

A. Computed interest will be calculated by multiplying the lesser of the necessary outstanding capital asset debt from the rate setting cost report or the facility asset value as determined in subparagraph (11)(D)1.C. by the interest rate. The interest rate is the prime rate plus two percent (2%), as follows:

(I) For the initial 1992 rate base year for rates effective for dates of service from January 1, 1995 through June 30, 2004, the interest rate shall be set using the Chase Manhattan prime rate in effect on the first business day of September as published in the *Wall Street Journal*, plus two percent (2%). The prime rate effective September 1, 1994 is 7.75% plus 2% equals a total interest rate of 9.75%. For replacement beds, additional beds, and new facilities placed in service after August 31, 1995, the prime rate will be updated annually on the first business day of each September based on the Chase Manhattan prime rate plus two (2) percentage points;

(II) For rates effective for dates of services beginning July 1, 2004, the interest rate is detailed in sections (20) and (21).

B. The following is an illustration of how computed interest is calculated:

	Example A: Facility Asset Value < Debt	Example B: Facility Asset Value > Debt
<i>Assumptions:</i>		
Facility asset value	\$2,000,000	\$4,331,573
Outstanding capital asset debt	\$2,500,000	\$2,371,094
Term of debt	25 years	25 years
Prime rate - September 2, 1994	7.75%	7.75%
<i>Computed interest calculation:</i>		
Facility asset value (Ex. A)	\$2,000,000	
Outstanding capital asset debt (Ex. B)		\$2,371,094
Interest rate (prime rate + 2%)	× 9.75%	× 9.75%
Computed interest	\$ 195,000	\$ 231,182

4. Borrowing costs.

A. A provider shall capitalize allowable borrowing costs and amortize them over the life of the loan on a straight-line basis.

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

C. The following is an illustration of how allowable borrowing costs are calculated, using the data from the interest calculation example detailed above in (11)(D)3.B.:

Assumptions:

Loan costs = \$120,000
 Discount costs = \$125,000
 Total borrowing costs = \$245,000

	<u>Example A</u>	<u>Example B</u>
Facility asset value	\$2,000,000	\$4,331,573
Outstanding capital asset debt	<u>/ 2,500,000</u>	<u>/ 2,371,094</u>
Percent of borrowing costs allowed	80%	100%
Borrowing costs	<u>×\$245,000</u>	<u>×\$245,000</u>
Allowable portion to be amortized	\$196,000	\$245,000
Term of debt	<u>/ 25 years</u>	<u>/ 25 years</u>
Allowable borrowing costs	\$7,840	\$9,800

5. Pass-through expenses.

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

- (I) Property insurance – line 109 of CR (7-93) and line 107 of CR (3-95);
- (II) Real estate taxes – line 111 of CR (7-93) and line 108 of CR (3-95);
- (III) Personal property taxes – line 112 of CR (7-93) and line 109 of CR (3-95);

6. Capital component per diem calculation. A per diem is calculated for each element detailed above in paragraph (11)(D)1.–5. which are then added together to determine the total capital cost component per diem.

A. Rental value, return and computed interest per diems. A per diem is calculated by dividing the rental value, the return and the computed interest by the computed patient days, rounded to the nearest cent. Computed patient days are equal to the total facility size (i.e., number of licensed beds plus equivalencies) determined in part (11)(D)1.A.(V) times three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(O) or the facility’s occupancy from the rate setting cost report. The following is an illustration of how this subparagraph (11)(D)6.A. is calculated:

	Allowable Cost	Computed Patient Days*	Per Diem
Rental value	\$108,289	56,079	\$1.93
Return	\$185,853	56,079	\$3.31
Computed interest (from Ex. B)	\$231,182	56,079	\$4.12

* Computed patient days:

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

Greater of minimum utilization or facility occupancy	<u>× 88.30%</u> **
Computed patient days	56,079

** Assumption: facility occupancy from the rate setting cost report = 88.30%

B. Borrowing costs/pass-through expenses per diems. A per diem is calculated by dividing the borrowing costs and the pass-through expenses by the greater of the minimum utilization days as determined in subsection (7)(O) or the facility's patient days from the rate setting cost report, rounded to the nearest cent. The following is an illustration of how subparagraph (11)(D)6.B. is calculated:

	Allowable Cost	Patient Days*	Per Diem
Borrowing costs (from Ex.B)	\$9,800	54,940	\$0.18
Pass-through expenses	48,142	54,940	\$0.88

*Patient days—the greater of:

a. minimum utilization days = $170 \times 366 \times 85\% = 52,887$

(Note: 1992 is a leap year; therefore, 366 days are used); or

b. facility patient days = 54,940 (Assumption—this is the number of actual patient days reported on rate setting cost report)

C. The capital cost component per diem is the sum of the per diems determined in subparagraphs (11)(D)6.A. and (11)(D)6.B.

Rental value	\$ 1.93
Return	\$ 3.31
Computed interest	\$ 4.12
Borrowing costs	\$ 0.18
Pass-through expenses	\$ 0.88
Total capital cost component per diem	\$10.42

(E) Working Capital Allowance. Each nursing facility's working capital per diem shall be equal to one and one-tenth (1.1) months of the sum of each facility's per diem for patient care, ancillary, and administration times the interest rate set forth in (11)(D)3., rounded to the nearest cent. The following is an illustration of how this subsection (11)(E) is calculated:

Patient care	\$38.00
Ancillary	\$ 6.00
Administration	<u>\$11.00</u>
Total per diem	\$55.00
Divided by 12 months	<u>12</u>
	\$ 4.58
Times 1.1 months	<u>1.1</u>
	\$ 5.04
Times Interest Rate	
(Prime + 2%)	<u>9.75%</u>
Working capital allowance per day	\$ 0.49

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

	Allowable	Cost Ceiling	Per Diem
Patient Care	\$38.00	\$40.00	\$38.00
Ancillary	\$ 8.00	\$ 6.00	\$ 6.00
Administration	\$12.00	\$11.00	\$11.00
Capital (FRV)	\$10.42		
Working capital allowance	<u>\$ 0.49</u>		
Total per diem	\$65.91		

(12) Reimbursement Rate Determination. A facility's reimbursement rate shall be determined by the division as described in this regulation. Any facility with an interim rate on December 31, 1994, shall be granted an interim rate effective for services on and after January 1, 1995, as prescribed in subsection (4)(HH), if applicable. A prospective rate determined from this regulation shall be retroactively effective for services beginning on the first day of the facility's second twelve- (12-) month fiscal year but not earlier than January 1, 1995, and shall replace the interim on and after January 1, 1995.

(A) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, and with a 1992 cost report on file with the division as of December 31, 1993, with a rate setting period ending in calendar year 1992 or prior shall be granted a prospective rate effective for service dates on and after January 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. The prospective rate shall be the greater of the following:

1. The per diem rate as determined in section (11); or
2. The prospective rate in effect for services rendered on January 1, 1994.

(B) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1993 shall have their prospective rate for services after December 31, 1994, based on the 1993 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the 1993 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 of 10.6% will be replaced with the 1994 and 1995 HCFA Market Basket Index of 3.4% and 3.3% respectively for a total of 6.7%; or
2. The prospective rate in effect for services rendered on January 1, 1994.

(C) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending in calendar year 1994 shall have their prospective rate for services after December 31, 1994, based on the 1994 rate setting cost report. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the 1994 desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 of 10.6% will be replaced with the 1995 HCFA Market Basket Index of 3.3%; or

2. The prospective rate in effect for services rendered on January 1, 1994.

(D) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after December 31, 1994, but before December 1, 1995, shall have their prospective rate for services after December 31, 1994, based on the rate setting cost report ending after December 31, 1994 but before December 1, 1995. For services before January 1, 1995, a prospective rate shall be determined on the basis of the allowable cost per patient day as determined by the division from the desk audited and/or field audited facility fiscal year cost report under regulations applicable on July 1, 1990. For services on or after January 1, 1995, a prospective rate will be the greater of the following:

1. The per diem rate as calculated in accordance with section (11), except the fiscal year ending after December 31, 1994 but prior to December 1, 1995, desk audited and/or field audited cost report will be used. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 will not be applied; or

2. The prospective rate in effect for services rendered on December 31, 1994.

(E) A facility with a valid Medicaid participation agreement in effect on December 31, 1994, which has a cost report with a rate setting period ending after November 30, 1995, shall have their prospective rate based on a rate setting cost report ending after November 30, 1995. A prospective rate will be effective for services on or after the first day of the rate setting period as determined in section (11), except the desk audited and/or field audited cost report ending after November 30, 1995, will be used. The 1993, 1994, and nine (9) months of 1995 HCFA Market Basket Index will not be applied.

(F) A facility entering the MO HealthNet program after December 31, 1994, shall receive an interim rate as defined in subsection (4)(HH) to be effective on the initial date of MO HealthNet certification. A prospective rate shall be determined in accordance with this regulation from the desk audited and/or field audited facility fiscal year cost report which covers the second full twelve- (12-) month fiscal year following the facility's initial date of MO HealthNet certification. The HCFA Market Basket Index for 1993, 1994, and nine (9) months of 1995 will not be applied. This prospective rate shall be retroactively effective and shall replace the interim rate for services beginning on the first day of the facility's second full twelve- (12-) month fiscal year.

(G) A facility with a valid Medicaid participation agreement in effect after December 31, 1994, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program, shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted with effective dates subsequent to the termination date but prior to reentry into the program as described in subsection (13)(A). This prospective rate shall be effective for service dates on and after the effective date of the reentry following a voluntary or involuntary termination.

(13) Adjustments to the Reimbursement Rates. Subject to the limitations prescribed elsewhere in this regulation, a facility's reimbursement rate may be adjusted as described in this section, 13 CSR 70-10.016, and 13 CSR 70-10.017.

(A) Global Per Diem Rate Adjustments. A facility with either an interim rate or a prospective rate may qualify for the global per diem rate adjustments as set forth in 13 CSR 70-10.016. Global per diem rate adjustments shall be added to the specified cost component ceiling.

(B) Special Per Diem Rate Adjustments. Special per diem rate adjustments may be added to a qualifying facility's rate without regard to the cost component ceiling if specifically provided as described below.

1. Patient care incentive. Each facility with a prospective rate on or after January 1, 1995, shall receive a per diem adjustment equal to ten percent (10%) of the facility's allowable patient care per diem subject to a maximum of one hundred thirty percent (130%) of the patient care median when added to the patient care per diem as determined in subsection (11)(A). This adjustment will not be subject to the cost component ceiling of one hundred twenty percent (120%) for the patient care median.

2. Ancillary incentive. Each facility with a prospective rate on or after January 1, 1995, and which meets one (1) of the following criteria shall receive a per diem adjustment:

A. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is below ninety percent (90%) of the ancillary median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) and ninety percent (90%) of the ancillary median. The following is an illustration of how the ancillary per diem adjustment is calculated:

120% of median	\$6.62
90% of median	\$4.97
Difference	\$1.65
1/2 the difference	<u> .83</u>
Per diem adjustment	\$.83

B. If the facility's allowable ancillary per diem as determined in subsection (11)(B) is between ninety percent (90%) and one hundred twenty percent (120%) of the median, the adjustment is equal to one-half (1/2) of the difference between one hundred twenty percent (120%) of the median and the facility's allowable ancillary per diem. The following is an illustration of how the ancillary per diem adjustment is calculated:

90% of median	\$4.97
120% of median	\$6.62
Ancillary per diem	\$5.21
Difference	\$1.41
1/2 the difference	<u> .71</u>
Per diem adjustment	\$.71

3. Multiple component incentive. Each facility with a prospective rate on or after January 1, 1995, and which meets the following criteria shall receive a per diem adjustment:

A. If the sum of the facility's patient care per diem and ancillary per diem, as determined in subsections (11)(A) and (B), is greater than or equal to sixty percent (60%) but less than or equal to eighty percent (80%), rounded to four (4) decimal places (.5985 or .8015 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

Percent of Total Per Diem Rate	Incentive
< 60%	\$0.00
> or = 60% but < 65%	\$1.15
> or = 65% but < 70%	\$1.30
> or = 70% but < 75%	\$1.45
> or = 75% but < or 80% =	\$1.60

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (13)(B)3.A. and the following calculation is greater than seventy-five percent (75%), rounded to four (4) decimal places (.7485 would not receive the adjustment): Medicaid days divided by the licensed nursing facility patient days from the facility's desk audited and/or field audited 1992 cost report. The adjustment is as follows:

Calculated Percentage	Incentive
< 75%	\$0.00
> or = 75% but < 80%	\$0.15
> or = 80% but < 85%	\$0.30
> or = 85% but < 90%	\$0.45
> or = 90% but < 95%	\$0.60
> or = 95%	\$0.75

4. 1967 *Life Safety Code* (LSC). Currently certified nursing facilities that must comply with a recent interpretation of paragraph 10-133 of the 1967 LSC which requires corridor walls to extend to the roof deck or achieve equivalency under the Fire Safety Evaluation System (FSES) will be reimbursed the reasonable and necessary cost to meet those standards required for compliance through their reimbursement rate. The reimbursement shall not be effective until the Department of Health and Senior Services has confirmed that the corrective action to comply with the 1967 LSC or FSES is operational and has reviewed the cost for compliance. Fire sprinkler systems shall be reimbursed over a depreciation life of twenty-five (25) years, and other alternative corrective action will be reimbursed over a depreciable life of fifteen (15) years. The division will use a desk audited and/or field audited cost report with the latest period ending in calendar year 1992 which is on file with the division as of December 31, 1993. This adjustment will be computed based on the documented cost submitted to the division as follows:

A. Depreciation. The cost incurred for the approved corrective action to continue in compliance divided by the depreciable useful life;

B. Interest. The interest cost incurred to finance this project shall be documented by a statement from the lending institution detailing the total interest cost of the loan period. The total interest cost will be divided by the loan period on a straight-line basis; and

C. The total of subparagraphs (13)(B)4.A. and B. will be divided by twelve (12) and then multiplied by the number of months covered by the 1992 cost report. This amount will be divided by the greater of actual patient days from the 1992 cost report or eighty-five percent (85%) of the licensed bed days from the 1992 cost report.

5. Any facility that had a 1967 LSC adjustment included in their December 31, 1994 reimbursement rate shall have that adjustment added to their January 1, 1995 reimbursement rate.

6. Replacement beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for replacement beds that resulted in the same number of beds being delicensed with the Department of Health and Senior Services. The facility shall provide documentation from the Department of Health and Senior Services that verifies the number of beds used for replacement have been delicensed from that facility. The rate adjustment will be calculated as the difference between the capital component per diem (fair rental value (FRV)) prior to the replacement beds being placed in service and the capital component per diem (FRV) including the replacement beds placed in service as calculated in subsection (11)(D) including the replacement beds placed in service. The capital component is calculated for the replacement beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the replacement beds are placed in service.

7. Additional beds. A facility with a prospective rate in effect on or after January 1, 1995, may request a rate adjustment for additional beds. The facility must obtain an approved certificate of need or applicable waiver for the additional beds. The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the additional beds being placed in service and the capital component per diem (FRV) including the additional beds as calculated in subsection (11)(D) including the additional beds placed in service. The capital component is calculated for the additional beds using the asset value per licensed bed as determined using the R. S. Means Construction Index for nursing facility beds adjusted for the Missouri indexes for the date the additional beds are placed in service.

8. Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request must be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request must clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment must be supported by complete, accurate, and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

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

B. Extraordinary circumstances, beyond the reasonable control of the nursing facility and is not a product or result of the negligence or malfeasance of the nursing facility, include:

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

(II) Vandalism and/or civil disorder that are not covered by insurance; and

C. The rate increase shall be calculated as follows:

(I) The one- (1-) time costs (costs that will not be incurred in future fiscal years)—

(a) To determine what portion of the incurred costs will be paid, the division will use the patient occupancy days from latest available quarterly occupancy survey from the Department of Health and Senior Services for the time period preceding when the extraordinary circumstances occurred; and

(b) The costs directly associated with the extraordinary circumstances will be multiplied by the above percent. This amount will be divided by the paid days for the month the rate adjustment becomes effective per paragraph (13)(B)8. This calculation will equal the amount to be added to the prospective rate for only one (1) month, which will be the month the rate adjustment becomes effective. For this one (1) month only, the ceiling will be waived;

(II) For ongoing costs (costs that will be incurred in future fiscal years): Ongoing annual costs will be divided by the greater of: annualized (calculated for a twelve- (12-) month period) total patient days from the latest cost report on file or eighty-five percent (85%) of annualized total bed days. This calculation will equal the amount to be added to the respective cost center, not to exceed the cost component ceiling. The rate adjustment, subject to ceiling limits, will be added to the prospective rate; and

(III) For capitalized costs, a capital component per diem (FRV) will be calculated as determined in subsection (11)(D). The rate adjustment will be calculated as the difference between the capital component per diem (FRV) prior to the extraordinary circumstances and the capital component per diem (FRV) including the extraordinary circumstances.

9. Quality Assurance Incentive.

A. Each nursing facility with an interim or prospective rate on or after July 1, 2000, shall receive a per diem adjustment of three dollars and twenty cents (\$3.20). The Quality Assurance Incentive adjustment will be added to the facility's current rate.

B. The Quality Assurance Incentive per diem increase shall be used to increase the expenditures to a nursing facility's direct patient care costs. Direct patient care costs include all expenses in the patient care cost component (i.e., lines 46 through 69 of Schedule B in the Title XIX Cost Report). Any increases in wages and benefits already codified in a collective bargaining agreement in effect as of July 1, 2000, will not be counted towards the expenditure requirements of the Quality Assurance Incentive as stated above. Nursing facilities with collective bargaining agreements shall provide such agreements to the division.

10. High volume adjustment. Effective for dates of service July 1, 2000, a high volume adjustment shall be granted to qualifying providers. A provider must qualify each July 1, the beginning of each state fiscal year (SFY), for the high volume adjustment and the adjustment will be effective for services rendered during the SFY, July 1 through June 30. For a provider who has a high volume adjustment on June 30, but does not qualify for the high volume adjustment on July 1 of the subsequent SFY, that provider's prospective rate will be reduced by the amount of the high volume adjustment included in the facility's prospective rate in effect June 30.

A. Each facility with a prospective rate on or after July 1, 2000, and which meets all of the following criteria shall receive a per diem adjustment:

(I) Have on file at the division a full twelve- (12-) month cost report ending in the third calendar year prior to the state fiscal year in which the adjustment is being determined (i.e., for SFY 2001, the third prior year would be 1998, for SFY 2002, the third prior year would be 1999, etc.);

(II) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds eighty-five percent (85%) of the total patient days for all nursing facility licensed beds;

(III) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care, ancillary, and administration cost components, as set forth in paragraphs (11)(A)1., (11)(B)1., and (11)(C)1., exceeds the per diem ceiling for each cost component in effect at the end of the cost report period; and

(IV) State owned or operated facilities shall not be eligible for this adjustment.

B. The adjustment will be equal to ten percent (10%) of the sum of the per diem ceilings for the patient care, ancillary, and administration cost components in effect on July 1 of each year. Effective July 1, 2002, the adjustment shall not accumulate from year-to-year.

C. The division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

D. Second tier high volume adjustment. Effective for dates of service July 1, 2002, a second tier high volume adjustment shall be granted to qualifying providers.

(I) If a nursing facility qualifies for the first tier high volume adjustment, as set forth above in subparagraph (13)(B)10.A., it may qualify for the second tier adjustment if it meets the following criteria:

(a) The Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds ninety-three percent (93%) of the total patient days for all nursing facility licensed beds;

(b) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care cost component, as set forth in paragraph (11)(A)1., exceeds one hundred twenty percent (120%) of the per diem ceiling for the patient care cost component in effect at the end of the cost report period; and

(c) The allowable cost per patient day as determined by the division from the applicable cost report for the administration cost component, as set forth in paragraph (11)(C)1., is less than one hundred fifty percent (150%) of the per diem ceiling for the administration cost component in effect at the end of the cost report period.

(II) The second tier high volume adjustment will be calculated as a percentage, to be determined by the Department of Social Services, of the sum of the per diem ceilings for the patient care, ancillary, and administration cost components in effect on July 1 of each year.

(a) The adjustment for State Fiscal Year 2003 shall be eighteen dollars and fifty-six cents (\$18.56) per Medicaid day.

(b) The adjustment for SFY 2004 shall be nineteen dollars and seventy-one cents (\$19.71) per Medicaid day.

(III) The adjustment shall be distributed based on a quarterly amount, in addition to per diem payments, based on Medicaid days determined from the paid day report from Missouri's fiscal agent for pay cycles during the immediately preceding state fiscal year.

(IV) The state share of the second tier high volume adjustment shall come from certified public funds. If the aggregate certified public funds are less than the state match required, the total aggregate second tier high volume adjustment will be adjusted downward accordingly.

(V) A nursing facility must qualify for the adjustment each year to receive the additional quarterly payments.

E. High volume adjustment for nursing facilities without a full twelve- (12-) month cost report. Effective for dates of service on or after January 17, 2003, the full twelve- (12-) month cost report requirement set forth in (13)(B)10.A.(I) shall include nursing facilities that have on file at the division two (2) partial year cost reports that when combined cover a full twelve- (12-) month period.

F. Medicaid hospice days to be included in determination of Medicaid occupancy. Effective for dates of service on or after January 17, 2003, the Medicaid patient days used to determine the Medicaid occupancy requirement set forth in part (13)(B)10.A.(II) shall be calculated by adding the days paid for by the Medicaid nursing facility program plus the days paid for by the Medicaid hospice program from the cost report identified in part (13)(B)10.A.(I).

G. State Fiscal Year (SFY) 2004 Ninety Percent (90%) Medicaid High Volume Grant.

(I) Effective for SFY 2004, additional one (1) time funding shall be provided to nursing facilities that qualify for the first tier high volume adjustment, as set forth above in subparagraph (13)(B)10.A., and whose Medicaid patient days as determined from the cost report identified in part (13)(B)10.A.(I) exceeds ninety percent (90%) of the total patient days for all nursing facility licensed beds.

(II) The SFY 2004 High Volume Grant will be calculated as a per diem adjustment based upon the funding appropriated by the general assembly and the Medicaid days incurred by the qualifying providers during SFY 2003. The adjustment for State Fiscal Year 2004 shall be two dollars and thirty-six cents (\$2.36) per Medicaid day.

(III) The adjustment shall be distributed based on a quarterly amount, in addition to per diem payments, based on Medicaid days determined from the paid days report from Missouri's fiscal agent for pay cycles during State Fiscal Year 2003.

H. High volume adjustment for nursing facilities placed in receivership.

(I) For facilities placed in receivership under Missouri law after December 31, 2001, the division shall make a determination as to whether the operator of the facility when the receivership ended (i.e., successor operator) is a related party to the facility placed in receivership. If the successor operator is determined to be an unrelated party and the facility was receiving the high volume adjustment prior to the receivership, the facility shall continue to receive the high volume adjustment during the receivership and until the adjustment is based on the first full year cost report prepared by the successor operator.

(II) Any adjustments contingent upon the facility qualifying for the high volume adjustment shall not be granted if the facility did not qualify for the high volume adjustment except as provided in part (13)(B)10.G.(I) above.

(III) This provision only applies until the first full year cost report is available, after which the facility must qualify for the high volume adjustment each year as specified in subparagraphs (13)(B)10.A., B., and C. in order to receive it.

11. Minimum Rate Adjustment. A minimum rate adjustment shall be granted to qualifying providers, as follows:

A. Effective for dates of service beginning July 1, 2001, the minimum Medicaid reimbursement rate for nursing facility services shall be eighty-five dollars (\$85).

12. Invasive Ventilator Care Adjustment. Effective for dates of service beginning January 1, 2013, a per diem adjustment shall be granted for ventilator services provided by qualifying providers to qualifying MO HealthNet participants as set forth in 13 CSR 70-10.017.

(C) Conditions for prospective rate adjustments. The division may adjust a facility's prospective rate both retrospectively and prospectively under the following conditions:

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

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

3. Court order; and

4. Disallowance of federal financial participation.

(14) Exceptions.

[(A) For those Medicaid-eligible recipients who have concurrent Medicare Part A skilled nursing facility benefits available, Medicaid reimbursement for covered days of stay in a qualified facility will be based on this coinsurance as may be imposed under Title XVIII.]

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

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

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

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

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

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

3. Once a Missouri nursing facility bed meeting the medical needs of the participant is available, the participant must return to Missouri to remain eligible for Missouri Medicaid program, unless the participant's health would be endangered if required to travel to Missouri. Participant's physician would need to certify that the participant's health would be endangered from the travel to Missouri.

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

[(B)] **5. The Title XIX reimbursement rate for out-of-state providers shall be set as follows:**

1. For out-of-state providers which provided services for Missouri Title XIX [recipients] participants, the reimbursement rate shall be [the rate paid for comparable services and level of care by the state in which the provider is located. The reimbursement rate will remain in effect until—] the lower of:

A. The weighted average MO HealthNet rate for comparable services at the beginning of the state fiscal year in which the provider enters the MO HealthNet program, or

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

[A] (I) Rate increases—[The division receives written notification of an increase in the provider's rate as issued by the state MO HealthNet agency in which the provider is located. The provider must also include a copy of the rate letter issued by their state detailing the rate and effective date.] If the provider notifies the division within thirty (30) days of receipt of notification from their state of the per diem rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter. If the division does not receive written notification from the provider within thirty (30) days of the date the provider received notification from their state of the rate increase, the effective date of the rate increase for purposes of reimbursement from Missouri shall be the first day of the month following the date the division receives notification; or

[B] (II) Rate decreases—[The division receives written notification of a decrease in the provider's rate as issued by the state Medicaid agency in which the provider is located including a copy of the rate letter issued by their state detailing the rate and effective date.] The effective date of the rate decrease for purposes of reimbursement from Missouri shall be the same date as indicated in the issuing state's rate letter.

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

1. For hospital based nursing facilities that have less than one thousand (1,000) Medicaid patient days, the rate base cost report will not be required. The prospective rate will be the sum of the ceilings for patient care, ancillary and administration, working capital allowance, and the median per diem for capital. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

2. For hospital based nursing facilities with a provider agreement in effect on December 31, 1994, a prospective rate shall be set by one (1) of the following:

A. The hospital based nursing facility requests, in writing, that their prospective rate be determined from their rate setting cost report as set forth in this regulation; or

B. The sum of the ceilings for patient care, ancillary, administration and working capital allowance, and the median per diem for capital from the permanent capital per diem in effect January 1, 1995 for the initial rate base year; July 1, 2004 for the 2001 rebased year; and March 15, 2005 for the revised rebase calculations effective for dates of service beginning April 1, 2005 and for the per diem rate calculation effective for dates of service beginning July 1, 2005 forward. In addition, the patient care incentive of ten percent (10%) of the patient care median will be granted.

(15) Sanctions and Overpayments.

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

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

(16) Appeals. In accordance with sections 208.156, RSMo and 622.055, RSMo providers may seek hearing before the Administrative Hearing Commission of final decisions of the director or the division.

(17) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full, for covered services rendered to Medicaid [*recipients*] **participants**, the amount paid in accordance with these regulations and other applicable payments.

(18) Provider Participation. Payments made in accordance with the standards and methods described in this regulation are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the regulation at least to the extent these services are available to the general public.

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

(20) Rebasing of Nursing Facility Rates.

(A) Effective July 1, 2004, nursing facility rates shall be rebased on an annual basis. The rebased rates shall be phased in as set forth below in subsection (20)(B). Each nursing facility shall have its prospective rate recalculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation, unless otherwise noted in this section (20). The following items have been updated to reflect the rebase:

1. Nursing facility rates shall be rebased on an annual basis using the cost report year that is three (3) years prior to the effective date of the rate change. For example, for SFY 2005, the effective date of the rate change is for dates of service beginning July 1, 2004 and the cost report year used to recalculate rates shall be 2001; for SFY 2006, the effective date of the rate change is for dates of service beginning July 1, 2005 and the cost report year used to recalculate rates shall be 2002; etc.

A. A new databank shall be developed from the cost reports for each rebase year in accordance with paragraph (20)(A)1. and subsection (4)(S).

B. The costs in the databank shall be trended using the indices from the most recent publication of the Health-Care Cost Review available to the division using the “CMS Nursing Home without Capital Market Basket” table. The costs shall be trended using the second quarter indices for each year. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2005, the trends are from the First Quarter 2004 publication of the Health-Care Cost Review and include the following:

(I) 2002:2 = 3.2%

(II) 2003:2 = 3.4%

(III) 2004:2 = 2.3%

(IV) 2005:2 = 2.3%

(V) The total trend applied to the 2001 cost report data is 11.2%.

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

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

2. The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be updated each year based upon the RS Means Building Construction Cost Data for the year coinciding with the effective date of the rates. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the “S.F., C.F., and % of Total Costs” table and adjusting it by the total weighted average index for Missouri cities from the “City Cost Indexes” table. For SFY 2005, the asset value shall be forty-one thousand seven hundred twenty-eight dollars (\$41,728);

3. The age of the beds shall be calculated from the year coinciding with the effective date of the rates;

4. The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be updated to reflect the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%);

5. The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be updated to reflect the interest (i.e., coupon) rate for the most recent issue of thirty- (30-) year Treasury Bonds in effect on the first business day of June for the year coinciding with the effective date of the rates plus two percent (2%). For SFY 2005, the rate of return shall be the thirty- (30-) year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%;

6. The administration cost component per diem calculation shall not be adjusted for minimum utilization;

7. The capital cost component per diem calculation shall be adjusted for minimum utilization using the Department of Health and Senior Services’ (DHSS) Intermediate Care Facility/Skilled Nursing Facility Certificate of Need Quarterly Survey (CON Quarterly Survey) for the most recent quarter available to the division relative to the effective date of the rates. The occupancy data from the CON Quarterly Survey shall be adjusted by the division using total licensed beds rather than available beds as is used by DHSS. For SFY 2005, the minimum utilization percent for the capital component is the adjusted industry average from the October–December 2003 CON Quarterly Survey and shall be seventy-three percent (73%);

8. The high volume adjustment for SFY 2005 shall continue to be based on the 2001 cost report rather than the cost report ending in the third calendar year prior to the state fiscal year as set forth in (13)(B)10.A.(I). The remaining criteria and calculations set forth in (13)(B)10. shall continue to be applicable. Therefore, facilities receiving the high volume adjustment for SFY 2004 shall continue to receive the same high volume adjustment for the first year of the rebase (i.e., July 1, 2004–June 30, 2005); and

9. Since rates are being recalculated each year, rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)6., (13)(B)7., and (13)(B)8. are no longer allowed.

(B) The rebased rates shall be phased in, as set forth below:

1. A preliminary rebased rate shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in paragraphs (20)(A)1.–9.

2. The total increase resulting from the rebase each year shall be calculated as follows:

A. Each facility's current rate as of June 30 of each year shall be compared to the preliminary rebased rate effective July 1 of the following SFY. For example, for SFY 2005, the facility's rate as of June 30, 2004 shall be compared to the preliminary rebased rate effective July 1, 2004; for SFY 2006, the facility's rate as of June 30, 2005 shall be compared to the preliminary rebased rate effective July 1, 2005; etc.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the current rate or the preliminary rebased rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraph (20)(B)2.B.

B. If the preliminary rebased rate is greater than the current rate, the difference between the two (2) shall represent the total increase that will be phased in by granting one-third (1/3) of the total increase each year. For SFY 2005, one-third (1/3) of the total increase shall be added to the facility's current rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility's prospective rate for SFY 2005.

C. If the preliminary rebased rate is less than the current rate, the facility shall continue to receive its current rate with any applicable adjustments for high volume and NFRA for the SFY.

(C) Interim rates and rates for hospital-based facilities that do not submit cost reports due to having less than one thousand (1,000) patient days for Medicaid residents shall also be recalculated and increases given each July 1 as set forth above.

(D) Effective for dates of service beginning April 1, 2005, the rebased rates for SFY 2005 shall be calculated as follows:

1. The audited 2001 cost report data shall continue to be used to develop the databank and to determine each nursing facility's rebased rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility's final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective April 1, 2005. The following items have been revised for the April 1, 2005 rate calculation:

A. A new databank shall be developed using the audited 2001 cost report data set forth above in paragraph (20)(D)1. for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S); and

B. The administration and capital cost components shall be adjusted for minimum utilization at eighty-five percent (85%) occupancy, rather than as set forth in paragraph (20)(A)6.-7.

(E) Prospective Rate Determination for Newly Medicaid Certified Nursing Facilities. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program and have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification. The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service. For example, for a rate setting period of January 1, 2004 through December 31, 2004, the facility's initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time and rate changes that occurred after January 1, 2004 shall be calculated in accordance with the regulation applicable to each rate change throughout the period, as follows: the facility's initial prospective rate effective January 1, 2004 shall be set in accordance with the regulations in effect at that time (sections (1)–(19)); nursing facility rates were rebased effective July 1, 2004 per section (20); the rebase provisions were modified effective April 1, 2005 under subsection (20)(D); the per diem rate calculation effective for dates of service beginning July 1, 2005 are detailed in section (21); a quality improvement adjustment of three dollars and seventeen cents (\$3.17) per day was granted effective July 1, 2006 in 13 CSR 70-10.016; etc.

1. A nursing facility that did not have a prospective rate established when rates were rebased on July 1, 2004, shall have its prospective rate for dates of service beginning on or after July 1, 2004 through June 30, 2005 established on the rate setting cost report in accordance with section (20), consistent with the rest of the nursing facility industry.

2. As set forth in paragraphs (20)(B)1. and 2., a preliminary rate shall be calculated and compared to the facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, to determine the total increase. The NFRA shall not be included in the preliminary rate or the June 30, 2004 rate for comparison purposes in determining the total increase.

A. If the facility will have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the prospective rate shall be the rate for comparison purposes in determining the total increase.

B. If the facility will not have a prospective rate established on June 30, 2004 once the prospective rate setting process is complete, the division will calculate a June 30, 2004 computed rate which will be used as the rate for comparison purposes in determining the total increase as follows:

(I) The rate setting cost report as determined in subsection (12)(F) shall be used.

(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the *Health-Care Cost Review* available to the division using the "CMS Nursing Home without Capital Market Basket" table. The allowable costs shall be negatively trended using the second quarter indices for each year, beginning with the index for the year relative to the end of the rate setting period back to and including the index for 2005. For example, a rate setting cost report for the period July 1, 2006 through June 30, 2007, shall have a 2007 rate setting year. The allowable costs shall be negatively trended by the 2007 second quarter index, the 2006 second quarter index, and the 2005 second quarter index. The resulting allowable costs shall be used to determine the June 30, 2004 computed rate.

(III) The computed rate shall be calculated in accordance with sections (1)–(19) of this regulation, prior to the rebase, using the regulations applicable to calculating a June 30, 2004 rate including the cost component ceilings, interest, rate of return, etc. in effect on June 30, 2004.

3. If the preliminary rate is greater than the June 30, 2004 rate, the facility shall receive one-third (1/3) of the total increase of the preliminary rate over the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The one-third (1/3) increase shall be added to the June 30, 2004 rate, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The NFRA in effect shall be added to that total to determine the prospective rate.

4. If the preliminary rate is less than the June 30, 2004 rate, the facility's June 30, 2004 rate plus the NFRA in effect shall become the prospective rate.

(21) Per Diem Rate Calculation Effective for Dates of Service Beginning July 1, 2005. Effective for dates of service beginning July 1, 2005, the rebase provisions set forth in section (20) shall not apply. Effective for dates of service beginning July 1, 2005, the per diem rates shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation, except that the data indicated in this section (21) shall be used.

(A) The audited 2001 cost report data shall be used to develop the databank and to determine each nursing facility's per diem rate. The audited 2001 cost report data; the licensed beds data; and the bed equivalencies data used to determine each nursing facility's final rate paid for dates of services effective July 1, 2004 shall be deemed final. This finalized data will be used as the base to calculate the rates effective July 1, 2005.

1. A new databank shall be developed using the audited 2001 cost report data set forth above in subsection (21)(A) for nursing facilities enrolled in the Medicaid program as of March 15, 2005 in accordance with subsection (4)(S).

2. The costs in the databank shall be trended using the second quarter indices from the First Quarter 2004 publication of the *Health-Care Cost Review* using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended for the years following the cost report year, up to and including SFY 2005. The trends applied to the 2001 cost report data include the following:

A. 2002:2 = 3.2%

B. 2003:2 = 3.4%

C. 2004:2 = 2.3%

D. 2005:2 = 2.3%

E. The total trend applied to the 2001 cost report data is 11.2%.

3. The medians and ceilings shall be recalculated, based upon the trended costs included in the new databank.

4. The costs, beds, days, renovations/major improvements, loans, etc. from each facility's cost report included in the databank shall be used to calculate each nursing facility's rate. The costs reflected in each facility's cost report shall be trended as detailed above in paragraph (21)(A)2.

(B) The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be based upon the 2004 publication of the RS Means Building Construction Cost Data. The asset value is determined by using the median, total cost of construction per bed for nursing homes from the "S.F., C.F., and % of Total Costs" table and adjusting it by the total weighted average index for Missouri cities from the "City Cost Indexes" table. The asset value shall be forty-one thousand seven hundred twenty-seven dollars and fifty cents (\$41,727.50).

(C) The age of the beds shall be calculated from 2004.

(D) The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be the prime rate as reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June 2004 plus two percent (2%). The interest rate shall be the prime rate of four percent (4%), as published June 1, 2004, plus two percent (2%) for a total of six percent (6%).

(E) The rate of return used in determining the capital cost component, as set forth in subsection (11)(D), shall be the interest (i.e., coupon) rate for the most recent issue of thirty- (30-) year Treasury Bonds in effect on the first business day of June 2004 plus two percent (2%). The rate of return shall be the thirty- (30-) year Treasury Bond rate of 5.375%, effective June 1, 2004, plus two percent (2%) for a total of 7.375%.

(F) The administration and capital cost components shall be adjusted for minimum utilization at eighty-five percent (85%) occupancy.

(G) The high volume adjustment shall continue to be that determined for SFY 2004. The 2001 cost report shall continue to be used rather than the cost report ending in the third calendar year prior to the state fiscal year as set forth in part (13)(B)10.A.(I), and the remaining criteria and calculations set forth in paragraph (13)(B)10. shall continue to be that used in the SFY 2004 calculation. Therefore, facilities receiving the high volume adjustment for SFY 2004 shall continue to receive that same high volume adjustment which will be included in its rate effective for dates of service beginning July 1, 2005.

(H) Rate adjustment requests for replacement beds, additional beds, and/or extraordinary circumstances as set forth in paragraphs (13)(B)6., (13)(B)7., and (13)(B)8. are no longer allowed.

1. Beginning State Fiscal Year 2016, an adjustment to the capital rate may be allowed for extraordinary circumstances as set forth in paragraph (13)(B)8. except the requirement that the occurrence is not covered by insurance does not have to be met. If a nursing facility is destroyed by an unavoidable act of nature beyond the control of the facility or vandalism and/or civil disorder the rebuilt nursing facility may apply for an adjustment to the capital component of the per diem rate, as calculated in part (13)(B)8.C.(III). The rate adjustment will be effective the date the rebuilt nursing facility is placed in service.

(I) Facility size and occupancy rate adjustment. If a facility qualifies for the facility size and occupancy rate adjustment, its facility size and occupancy rate shall be adjusted and used in the calculation of its per diem rate.

1. Qualifying criteria. A nursing facility may qualify for a facility size and occupancy adjustment if it meets all of the following criteria:

A. The facility has been operating only fifty percent (50%) of its licensed bed capacity; and

B. Every resident has been residing in a private room; and

C. The facility has been operating as such (as detailed in subparagraphs A. and B. above) from the beginning of their 2001 cost report period through the date the rate is effective as reported on the quarterly survey form, "Missouri Department of Health and Senior Services, Division of Senior Services and Regulation, ICF/SNF Certificate of Need Quarterly Survey" (form MO 886-9001(6-95)) (quarterly survey); and

D. The facility's intent for operating as such is to qualify for a Certificate of Need (CON) in accordance with section 197.318.9, RSMo 2000.

2. Calculation of adjusted facility size, adjusted occupancy rate, and adjusted per diem rate.

A. Adjusted facility size. The facility size as defined in subsection (4)(BB) and used in the determination of a facility's capital cost component under the fair rental value system set forth in subsection (11)(D) shall be adjusted to reflect fifty percent (50%) of the licensed bed capacity.

B. Adjusted occupancy rate. The occupancy rate as defined in subsection (4)(MM) shall be adjusted to reflect fifty percent (50%) of the licensed bed capacity by adjusting the bed days used to determine the occupancy rate. The bed days shall be calculated using fifty percent (50%) of the licensed bed capacity and the adjusted occupancy rate shall be calculated by dividing the facility's total actual patient days by the adjusted bed days.

C. The adjusted facility size and the adjusted occupancy rate shall be used to determine the facility's per diem rate in accordance with the remaining provisions of this regulation.

3. The facility must notify the division in writing that it qualifies for this adjustment and provide the proper documentation, including the following:

A. A copy of the quarterly surveys from the beginning of the 2001 cost report period through the date the rate is effective; and

B. A copy of an approved CON obtained under section 197.318.9, RSMo 2000, or a written statement indicating the facility's intention of obtaining a CON under section 197.318.9, RSMo 2000, including a specific time line detailing when they plan to apply for the CON and when they plan to begin construction relative to the CON;

C. The division shall accept such written notification from facilities that qualify for this adjustment as of July 1, 2005 for up to thirty (30) days after the effective date of this amendment.

4. This adjustment shall only apply to nursing facilities with a prospective rate on July 1, 2005 and shall only be granted for the July 1, 2005 rate calculation.

5. Loss of facility size and occupancy rate adjustment and recalculation of per diem rate. If a facility's per diem rate has been set using an adjusted facility size and an adjusted occupancy rate and at least one (1) of the conditions set forth below in subparagraphs (21)(I)5.A.(I)–(IV) is met, the facility will no longer receive the adjustment to the facility size and occupancy rate in determining its per diem rate and its per diem rate shall be recalculated.

A. The conditions for losing the facility size and occupancy rate adjustment include the following:

(I) The facility ceases to operate at fifty percent (50%) of its licensed bed capacity; or

(II) The facility ceases to operate with every resident residing in a private room; or

(III) The facility does not apply for a CON under section 197.318.9, RSMo 2000 within five (5) years of receiving the adjustment; or

(IV) The facility does not begin the construction relative to the CON obtained under section 197.318.9, RSMo 2000 within five (5) years of receiving the adjustment.

B. If the facility size and occupancy rate adjustment is lost, the facility's per diem rate shall be recalculated using the unadjusted facility size as set forth in subsection (4)(BB) and the unadjusted bed days and unadjusted occupancy rate as set forth in subsection (4)(MM).

C. The facility must notify the division within thirty (30) days if it no longer qualifies for the facility size and occupancy rate adjustment as a result of meeting one (1) of the conditions listed above in subparagraph (21)(I)5.A.

(I) If the facility notifies the division of such within thirty (30) days, the effective date of the rate recalculation shall be the date that one (1) of the conditions set forth above in subparagraph (21)(I)5.A. is met. If more than one (1) of the conditions apply, the effective date shall be the earliest date. The facility shall repay the division any overpayment resulting from the loss of the facility size and occupancy rate adjustment.

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

(J) The rates effective for dates of service beginning July 1, 2005 shall be determined, as set forth below:

1. A preliminary rate for July 1, 2005 shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed above in subsections (21)(A)–(I).

2. The total increase resulting from the July 1, 2005 preliminary rate calculation shall be calculated as follows:

A. Each facility's rate as of June 30, 2004, less the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, shall be compared to the July 1, 2005 preliminary rate calculation.

(I) The high volume adjustment, if applicable, and the NFRA shall not be included in the June 30, 2004 rate or the July 1, 2005 preliminary rate for comparison purposes in determining the total increase.

(II) The high volume adjustment, if applicable, and the current NFRA shall be added to the rate determined below in subparagraphs (21)(J)2.B. and (21)(J)2.C.;

B. If the July 1, 2005 preliminary rate is greater than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, the difference between the two (2) shall represent the total increase. Effective for dates of service beginning July 1, 2005, one-third (1/3) of the total increase shall be added to the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016. The high volume adjustment, if applicable, and the current NFRA shall be added to that total and shall be the facility's prospective rate for dates of service beginning July 1, 2005;

C. If the July 1, 2005 preliminary rate is less than the June 30, 2004 rate including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016, the facility's prospective rate shall be the facility's rate as of June 30, 2004 including the reduction in the nursing facility operations adjustment of fifty-four cents (54¢) effective July 1, 2004 as set forth in 13 CSR 70-10.016 plus the high volume adjustment, if applicable, and the current NFRA.

(K) Interim rates and rates for hospital-based facilities that do not submit cost reports due to having less than one thousand (1,000) patient days for Medicaid residents shall also be recalculated and increases given as set forth above.

(L) Prospective Rate Determination for Nursing Facilities Newly Medicaid Certified after June 30, 2004. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program and have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification. The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service. For example, for a rate setting period of January 1, 2006 through December 30, 2006, the facility's initial prospective rate effective January 1, 2006 shall be set in accordance with the regulations in effect at that time and rate changes that occurred after January 1, 2006 shall be calculated in accordance with the regulation applicable to each rate change throughout the period, as follows: the facility's initial prospective rate effective January 1, 2006 shall be set in accordance with the regulations in effect at that time, section (21) (i.e., the per diem rate calculation effective for dates of service beginning July 1, 2005 are detailed in section (21)); a quality improvement adjustment of three dollars and seventeen cents (\$3.17) per day was granted effective July 1, 2006 in paragraph (13)(A)10.; etc.

1. A nursing facility never previously certified for participation in the Medicaid program that originally enters the Medicaid program after June 30, 2004 shall have its prospective rate for dates of service beginning on or after July 1, 2005 calculated in accordance with the provisions of section (21), consistent with the rest of the nursing facility industry. The following items shall be updated annually and shall be used in determining the prospective rate, as follows:

A. Asset value. The asset value used to determine the capital cost component, as set forth in subsection (11)(D), shall be adjusted annually based upon the R. S. Means Building Construction Cost Data published each year using the "Historical Cost Indexes" table. The asset value for the year relative to the end of the rate setting period shall be used;

B. Age of beds. The age of the beds shall be calculated by subtracting the year the beds were originally licensed from the year relative to the end of the rate setting period;

C. Interest rate. The interest rate used in determining the capital cost component and working capital allowance, as set forth in subsections (7)(F), (11)(D), and (11)(E), shall be updated annually using the prime rate reported by the Federal Reserve and published in the *Wall Street Journal* on the first business day of June of each year plus two percent (2%). The interest rate in effect at the end of the rate setting period shall be used.

2. A preliminary rate at the beginning of the rate setting period shall be calculated using the same principles and methodology as detailed throughout sections (1)–(19) of this regulation and the updated items detailed in section (21).

3. The preliminary rate at the beginning of the rate setting period shall be compared to a June 30, 2004 computed rate as detailed below to determine the total increase. The NFRA shall not be included in the preliminary rate or the June 30, 2004 computed rate for comparison purposes in determining the total increase.

A. The June 30, 2004 computed rate for comparison purposes shall be calculated as follows:

(I) The rate setting cost report as determined in subsection (12)(F) shall be used;

(II) The allowable costs from the rate setting cost report will be negatively trended back to June 30, 2004 using the indices from the most recent publication of the *Health-Care Cost Review* available to the division using the “CMS Nursing Home without Capital Market Basket” table. The allowable costs shall be negatively trended using the second quarter indices for each year, beginning with the index for the year relative to the end of the rate setting period back to and including the index for 2005. For example, a rate setting cost report for the period July 1, 2006 through June 30, 2007, shall have a 2007 rate setting year. The allowable costs shall be negatively trended by the 2007 second quarter index, the 2006 second quarter index, and the 2005 second quarter index. The resulting allowable costs shall be used to determine the June 30, 2004 computed rate;

(III) The computed rate shall be calculated in accordance with sections (1)-(19) of this regulation, prior to the rebase, using the regulations applicable to calculating a June 30, 2004 rate including the cost component ceilings, interest, rate of return, etc. in effect on June 30, 2004.

B. If the preliminary rate at the beginning of the rate setting period is greater than the June 30, 2004 computed rate, the facility shall receive one-third of the total increase of the preliminary rate over the June 30, 2004 computed rate. The one-third increase shall be added to the facility’s June 30, 2004 computed rate. The NFRA in effect shall be added to the total and shall be the facility’s prospective rate effective at the beginning of the rate setting period.

C. If the preliminary rate at the beginning of the rate setting period is less than the June 30, 2004 computed rate, the facility’s June 30, 2004 computed rate plus the NFRA in effect shall become the prospective rate effective the beginning of the rate setting period.

(M) Prospective Rate Determination for Previously Medicaid Certified Nursing Facilities Reentering the Medicaid Program. As set forth in subsection (12)(G), a nursing facility that was previously certified for participation in the Medicaid Program and either voluntarily or involuntarily terminated from the Medicaid Program which then reenters the Medicaid Program shall have its prospective rate established as the rate in effect on the day prior to the date of termination from participation in the program plus rate adjustments which may have been granted subsequent to the termination date but prior to reentry into the program. The prospective rate for nursing facilities that reentered the Medicaid Program after nursing facility rates were rebased July 1, 2004 shall be calculated as follows:

1. If there is a 2001 cost report for the nursing facility, regardless of the owner/operator who completed the 2001 cost report, the prospective rate shall be based on the 2001 cost report in accordance with section (21); or

2. If there is not a 2001 cost report for the nursing facility, the prospective rate in effect when the facility terminated from the program shall be adjusted to reflect the rate changes granted through June 30, 2004 and shall be the June 30, 2004 rate to be compared to the preliminary rebased interim rate to determine the total increase, the one-third increase and the rebased prospective rate, in accordance with section (21), consistent with the rest of the nursing facility industry.

(N) Nursing facilities who qualify to have their prospective rate set in accordance with the provisions of subsection (20)(E) shall continue to receive the rate determined from subsection (20)(E) for dates of service beginning July 1, 2005.

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

(A) Prospective Rate Determination for Nursing Facilities Newly Medicaid Certified after June 30, 2004. As set forth in subsection (12)(F), a nursing facility never previously certified for participation in the Medicaid program shall receive an interim rate upon entering the Medicaid program. The nursing facility shall have its prospective rate set on its second full twelve- (12-) month cost report following the facility's initial date of certification, referred to as the rate setting cost report. The period to which the rate setting cost report relates is referred to as the rate setting period.

(B) The prospective rate shall be calculated in accordance with the provisions of the regulation in effect from the beginning of the facility's rate setting period through the date the prospective rate is determined, as detailed below. If industry-wide rate changes were implemented during this period the provision of the regulation relating to the effective date of the rate change shall be the governing regulation for those dates of service.

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

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

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

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

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

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

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

A. The total rate cap in effect on November 1, 2020 is \$190.00; and,

B. The total rate cap set forth above, \$190.00, shall be adjusted by any global per diem adjustments granted after November 1, 2020; and,

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

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

APPENDIX A
COVERED SUPPLIES AND SERVICES
PERSONAL CARE

Baby powder
Bedside tissues
Bibs, all types
Deodorants
Disposable underpads of all types
Gowns, hospital
Hair care, basic including washing, cuts, sets, brushes, combs, nonlegend shampoo
Lotion, soap, and oil
Oral hygiene including denture care, cups, cleaner, mouthwashes, toothbrushes, and paste
Shaves, shaving cream, and blades
Nail clipping and cleaning routine

EQUIPMENT

Arm slings
Basins
Bathing equipment
Bed frame equipment including trapeze bars and bedrails
Bed pans, all types
Beds, manual, electric
Canes, all types
Crutches, all types
Foot cradles, all types
Glucometers
Heat cradles
Heating pads
Hot pack machines
Hypothermia blanket
Mattresses, all types
Patient lifts, all types
Respiratory equipment: compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment, and related -supplies, etc.
Restraints
Sand bags
Specimen container, cup or bottle
Urinals, male and female
Walkers, all types
Water pitchers
Wheelchairs, standard, geriatric, and roll-about

NURSING CARE/PATIENT CARE SUPPLIES

Catheter, indwelling and nonlegend supplies

Decubitus ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads, and/or turning frames, heel protectors, donuts and sheepskins
Diabetic blood and urine testing supplies
Douche bags
Drainage sets, bags, tubes, etc.
Dressing trays and dressings of all types
Enema supplies
Gloves, nonsterile and sterile
Ice bags
Incontinency care including pads, diapers, and pants
Irrigation trays and nonlegend supplies
Medicine droppers
Medicine cups
Needles including, but not limited to, hypodermic, scalp, vein
Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel
Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A and D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings and bandages of all types, cottonballs, and aerosol merthiolate, tongue depressors
Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags
Suture care including trays and removal kits
Syringes, all sizes and types including -ascepto
Tape for laboratory tests
Urinary drainage tube and bottle

THERAPEUTIC AGENTS AND SUPPLIES

Supplies related to internal feedings
I.V. therapy supplies: arm boards, needles, tubing, and other related supplies
Oxygen (portable or stationary), oxygen delivery systems, concentrators, and supplies
Special diets

AUTHORITY: section 208.159, RSMo 2000, and sections 208.153 and 208.201, RSMo Supp. 2013.
Emergency rule filed Dec. 21, 1994, effective Jan. 1, 1995, expired April 30, 1995. Emergency rule filed April 21, 1995, effective May 1, 1995, expired Aug. 28, 1995. Original rule filed Dec. 15, 1994, effective July 30, 1995. For intervening history, please consult the **Code of State Regulations**.*

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

PUBLIC COST: This proposed amendment will cost state agencies or political subdivisions approximately \$2.8 million in SFY 2021.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Department of Social Services, Legal Services Division-Rulemaking, P.O. Box 1527, Jefferson City, MO 65102-1527, or by email to Rules.Comment@dss.mo.gov. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

DRAFT