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

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

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

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

D. Relative means persons related by blood or marriage to the fourth degree of consanguinity; and

E. Entity means any person, corporation, partnership, or association.

~~(N) Rural. Those counties which are not defined as urban.~~

~~(O) Urban. The urban counties are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.~~

(4) ICF/IID Rate Computation. Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program. Rate determination shall be based on reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined.

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

1. The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per diem rate. Facilities with less than a full twelve- (12) month 1985 fiscal year will not have their base year rates updated.

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

(c) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system**.**

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

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

E. Disallowance of federal financial participation.

F. The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this plan.

~~(5) Covered Services and Supplies.~~

~~(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:~~

~~1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;~~

~~2. Items which are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;~~

~~3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;~~

~~4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;~~

(C) Per Diem Rate Calculation Effective for Dates of Service Beginning October 1, 2022. Effective for dates of service beginning October 1, 2022, nonstate-operated ICF/IID per diem rates shall be rebased using the facilities' 2021 fiscal year end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its prospective rate recalculated based on their 2021 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1) – (13) of this plan. If the nonstate-operated ICF/IID does not have a full, twelve- (12-) month 2021 fiscal year end cost report, the 2020 fiscal year cost report shall be used to calculate the prospective rate.

(I) The costs from the 2020 and 2021 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four quarter moving average. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2023, the trends are as follows:

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

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

(III) The division will use the FY 2021 cost report to determine the ICF/IID prospective rate, set forth as follows. If the FY 2020 fiscal year end cost report is used to set the rate instead of the FY 2021 cost report, an additional year of trend will be applied to the methodology that is set forth below.

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

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

Licensed/Certified Bed Days (9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88.28%
Bed Days @ Minimum Occupancy of 90% (3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization Adjustment (Unused Capacity / 90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity (Greater of 90% of Bed Days or Total Patient Days)	2,957
* Minimum Utilization Adjustment	
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Expense	$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	$4,323

Patient Care	$400,000
Ancillary	$10,000
Dietary	$25,000
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Routine Service Cost	$659,000
Less: Minimum Utilization Adjustment *	($4,323)
Routine Service Cost, Adjusted for Minimum Utilization	$654,677
SFY 2021 Trend	0.000%
SFY 2022 Trend	2.500%
SFY 2023 Trend	3.375%
Trended Routine Service Cost	$693,692
Total Patient Days	2,900
Routine Service Cost Per Diem	$239.20

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2022 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

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

SFY 2022 ICF/IID FRA Assessment	$40,000
Total Patient Days	2,900
ICF/IID FRA Per Diem	$13.79

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

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

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

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

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

Investment Capital			
	Equipment	Building	Total
Cost	$130,000	$300,000	$430,000
Less: Prior Years Depreciation	($120,000)	($225,000)	($345,000)
Less: Current Year Depreciation	($2,400)	($8,500)	($10,900)
Total Investment Capital	$7,600	$66,500	$74,100

Working Capital	
Total Expenses	$693,692
Divided by 12 Months	12
	$57,808
Times 1.1 Months	1.1
Total Working Capital	$63,589

Net Equity (Investment Capital + Working Capital)	$137,689
Rate of Return	4.375%
Return on Equity	$6,024
Minimum Utilization Days	2,957
Return on Equity Per Diem	$2.04

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

Routine Service Cost per diem	$239.20
ICF/IID FRA per diem	$13.79
Return on Equity per diem	$2.04
Total Calculated Per Diem	$255.03

Current Per Diem Rate	$230.00
Rebased Per Diem Rate	$255.03

(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

2. Interim Rate Calculation.

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

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

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost report) prepared in accordance with the principles of this plan. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7).

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

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

3. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

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

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

(I) When the provider can show that it incurred higher costs due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, and the costs have a substantial cost effect;

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

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

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

(c) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system.

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

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

E. Disallowance of federal financial participation.

F. The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this plan.

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

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

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;