

Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services

**SFY 2023
Reimbursement Methodology Implementing
Acuity Adjustments
and
Value Based Purchasing**

Draft

**This is the Draft SPA
Submitted to the
Center for Medicare & Medicaid Services (CMS)
On 9/19/2022**

**Language Contained in this Draft Document
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Until Approved by CMS**

Prospective Reimbursement Plan for Nursing Facility and HIV Nursing Facility Services

(1) Authority. This plan is established pursuant to the authorization granted to the Department of Social Services (department), MO HealthNet Division (division).

(2) Purpose. This plan establishes a methodology for determination of reimbursement rates for nursing facilities and HIV nursing facilities participating in the MO HealthNet Program, which is Missouri's Medicaid program. Hereinafter, the term nursing facility/ies shall refer to both nursing facilities and HIV nursing facilities unless specifically stated otherwise. Subject to limitations prescribed elsewhere in this plan, a facility's reimbursement rate shall be determined by the division as described in this plan. 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 plan shall apply only to facilities certified for participation in the MO HealthNet (Medicaid) Program.

(B) The reimbursement rates determined by this plan shall apply only to services provided on or after July 1, 2022.

(C) The effective date of this plan shall be July 1, 2022.

(D) The Medicaid Program shall provide reimbursement for nursing facility services based solely on the individual Medicaid-eligible participant's covered days of care, within benefit limitations as determined in subsections (5)(D), 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. Where third-party payment is involved, Medicaid will be the payer of last resort with the exception of state programs such as vocational rehabilitation and the Missouri Crippled Children's Services.

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(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 plan.

(F) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible 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 Missouri Medicaid Audit and Compliance division of the Department of Social Services.

(I) The division shall recover liabilities, sanctions, and penalties pertaining to the Medicaid Program associated with the provider number, regardless of when the services were rendered.

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

(K) A facility with certified and noncertified 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 MO HealthNet Program on the same date as the Medicare termination.

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

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(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 plan may be reevaluated in light of the provider's cost experience to determine any adjustments needed.

(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 end of the cost report period. 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 plan are for illustration purposes only and are not meant to be actual calculations.

(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

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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;

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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) Administration. This cost component includes costs reported in the cost report on lines 111-150.

(B) Age of beds. The age is determined by subtracting the initial licensing year from the rate base year used to determine the prospective rate.

(C) Allowable cost. Those costs which are allowable for allocation to the Medicaid Program based upon the principles established in this plan. The allowability of costs shall be determined by the MO HealthNet Division and shall be based upon criteria and principles included in this plan, the *Medicare Provider Reimbursement Manual* (CMS Publications 15-1 and 15-2), and GAAP. Criteria and principles will be applied using this plan as the first source, the *Medicare Provider Reimbursement Manual* as the second source, and GAAP as the third source.

(D) Ancillary. This cost component includes costs reported in the cost report on lines 71-101.

(E) 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 (FRV) system as set forth in subsection (11)(D).

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1. The 2019 asset value used in setting rates effective July 1, 2022 is sixty-four thousand seven hundred one dollars (\$64,701) and is calculated as follows:

A. The median cost per square foot for nursing facilities of one hundred fifty-six dollars (\$156) is multiplied by the average square feet per bed of 435. This product is adjusted for Missouri cities. The sources of the data are as follows:

(I) Median cost per square foot – *2019 Building Construction Costs with RSMeans data* publication, 50 17 / Project Costs table, Unit Costs Median of Total Project Costs for Nursing Home and Assisted Living.

(II) Average square feet per bed - 2019 cost report data bank.

(III) Adjustment for Missouri cities - *2019 Building Construction Costs with RSMeans data* publication, City Cost Indexes table, Weighted Average index for Missouri cities.

2. The 2019 asset value is adjusted annually on July 1 using the Historical Cost Indexes table from the *Building Construction Costs with RSMeans data* publication for each year.

3. The adjusted asset values will be used to update the capital rate annually as set forth in (11)(H)4. and to set the prospective rate for new facilities. The asset value for the year relative to the rate base year (i.e., the end of the rate setting period) shall be used to determine the prospective rate for new facilities.

(F) 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 limited 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, but is not limited to, items such as a comparative analysis of a provider's cost report data to industry data, a review of a provider's prior year data to determine any outliers that may warrant further review, requesting additional details of the reported information, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. 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, but is not limited to, 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 or documentation to support amounts reflected in the cost report, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level II audits may be provided off-site; and

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3. Level III Audit – Requires an in depth audit, including, but not limited to, 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, all of which could lead to potential adjustment(s) after such further review, as well as making any standard adjustments. Level III audits will require some portions of the provider’s records review be provided on-site.

(G) Average private pay rate. The usual and customary charge for private pay patients determined by dividing total private patient days of care into private pay revenue, net of contractual allowances, for the same service that is included in the Medicaid reimbursement rate. Private pay revenue 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 not subtracted from private pay revenue in the computation of the average private pay rate.

(H) Bad debt. The difference between the amount expected to be received (i.e., revenues less contractual allowance) 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) Bed days. The total number of days that are available to care for patients based on a facility’s total licensed beds, regardless of whether the bed is occupied or not. 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 of the cost report, bed days are calculated by multiplying the number of beds certified during the cost report period times the days in the cost report period.

(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 in the cost report on lines 102-110.

(K) Capital asset. A facility’s building, building equipment, major moveable equipment, minor equipment, land, land improvements, and leasehold improvements as defined in the Medicare Provider Reimbursement Manual. Motor vehicles are excluded from this definition.

(L) Capital asset debt. The debt related to the capital assets as determined from the cost report.

(M) Capital expenditures. Capital costs incurred for improving a facility.

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(N) Case Mix Index (CMI). Weight or numeric score assigned to a resident classification system (e.g. Resource Utilization Group (RUG), Patient-Driven Payment Model (PDPM), etc.) grouping to reflect the relative resources predicted to care for a resident. The average acuity level of patients in a facility can be determined and expressed by calculating an average of the individual CMI values for each resident. Resident classifications are determined from information derived from the Minimum Data Set (MDS) evaluations for a given period.

1. Individual CMIs are calculated as follows:

A. The RUG IV, 48 groups, Logic Version 1.03, CMI Set F01 (48-Grp) (i.e., RUG IV 48 group model classification system) is used to determine the CMIs used in this plan and is incorporated by reference and made a part of this plan as published by CMS at its website <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation>. Applicable files are RUG-IV DLL Package V1.04.1 Final.zip and RUG III Files & RUG IV Files.zip.

B. Providers should follow CMS guidelines for completing and submitting MDS assessments. No extra MDS assessments are required as a result of this plan;

C. The index maximizing methodology is used to calculate the individual CMI. The index maximizing classification system will select the RUG with the highest CMI for individuals that qualify for multiple RUGs;

2. Facility CMIs are calculated as follows:

A. Facility CMI calculations will be based on quarterly point-in-time data snapshots. These snapshot dates are January 1, April 1, July 1 and October 1;

B. The midnight census will determine the residents that are included in the facility's CMI;

C. The Assessment Reference Date (ARD) will be used to determine the assessment included in each quarterly CMI calculation;

D. A look-back period of one hundred eighty (180) days will be used to determine the residents included in calculating the facility CMI. The look-back period cutoff date is the day prior to the snapshot date (i.e., for the January 1 CMI calculation, the ARD would need to be December 31 or earlier).

E. The most current MDS assessment generating a RUG classification for an individual in the look-back period of one hundred eighty (180) days will be used;

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F. Active residents (those without a discharge tracking document) with no assessment in the look-back period will be classified into the case mix category with the lowest CMI;

G. Only assessments that are included in the MDS data sent to the State through the CMS system will be available for case mix calculations;

H. An average acuity level will be determined for each facility for each snapshot date by using a simple average of the CMI values for all residents included in the data for the snapshot date.

(I) Medicaid CMI. The average acuity level for Medicaid patients in a facility.

(a) Medicaid pending residents will be included in the facility's Medicaid CMI calculation;

(b) Medicaid hospice residents will be included in the facility's Medicaid CMI calculation;

(c) Medicaid manage care residents will be included in the facility's Medicaid CMI calculation;

(II) Total CMI. The average acuity level for all patients in a facility.

(O) 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.

(P) Certified bed. Any licensed nursing facility or hospital based bed that is approved by the Department of Social Services to participate in the Medicaid Program.

(Q) Change of ownership. A change in ownership, control, operator, or leasehold interest, for any facility certified for participation in the Medicaid Program.

(R) Charity care. Offset to gross billed charges to reduce charges for free services provided to specific types of residents, (i.e., charity care provided by a religious organization for members, etc.).

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(S) CMS Market Basket Index. An index that measures the price movements of goods, services, and labor purchased by nursing homes. The index is published quarterly in the *IHS Markit / Healthcare Cost Review*. The "Total - %MOVAVG" index from "Table 6.7 CMS Nursing Home without Capital Market Basket" shall be used for the trending calculations in this plan. The same or comparable index and table shall continue to be used, regardless of any changes in the name or title of the publication, publisher, or table.

(T) 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.

(U) Cost components. The groupings of allowable costs used to calculate a facility's per diem rate. They are patient care, ancillary, capital, and administration.

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

1. Cost Report version MSIR-1 (3-95) and cost report instructions (revised 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).

(W) Data bank. The data from the rate base year cost reports used to determine the medians, ceilings, and per diem rates for nursing facilities.

1. A separate data bank shall be created for nursing facilities and HIV nursing facilities, as follows:

A. The data bank for nursing facilities shall include all nursing facilities except hospital based facilities and HIV facilities.

B. The data bank for HIV nursing facilities shall only include HIV nursing facilities.

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2. 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.

3. Nursing facilities that terminated from the MO HealthNet program during the rate base year shall not be included in the data bank.

4. Nursing facilities operating under an interim rate that have at least a second full year cost report after entering the Medicaid program that coincides with the rate base year may be included in the data bank. Interim rate facilities without such a cost report for the rate base year shall not be included in the data bank.

5. The initial rate base year used for rebasing shall be 2019 and the data bank shall include cost reports with an ending date in calendar year 2019. The 2019 rebase year data shall be used to set rates effective for dates of service beginning July 1, 2022 through such time rates are rebased again or calculated on some other cost report as set forth in plan. The 2019 year data shall be adjusted for the following and shall be used to determine the medians, ceilings, and per diem rates for the nursing facilities:

A. The following allowable salaries shall be adjusted by two percent (2%):

- (I) Aides and Orderlies (Line 53 of CR (3-95));
- (II) Dietary Salaries (Line 60 of CR (3-95));
- (III) Laundry Salaries (Line 85 of CR (3-95));
- (IV) Housekeeping Salaries (Line 91 of CR (3-95)); and,
- (V) Beauty & Barber Salaries (Line 94 of CR (3-95)).

B. The total allowable costs, including the salary adjustments detailed above in (4)(W)5.A., shall be trended through June 30, 2022 by the difference in the CMS Market Basket Index (i.e., the "Total – %MOVAVG" index for 2022:2 from the First-quarter 2021 publication) and the midpoint of the facility's rate setting cost report year.

C. The total patient care costs, including the salary adjustments and trends, shall be adjusted to match the statewide average total CMI by multiplying the total patient care costs by the quotient of the statewide average total CMI divided by the facility cost report total CMI.

(I) A cost report total CMI is determined for each facility based on a simple average of the four (4) quarterly total CMIs covering the facility's cost report period.

(II) The statewide total CMI is a simple average of the cost report CMIs for all nursing facilities included in the databank.

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(X) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(Y) 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.

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

(AA) 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.

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

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

(DD) Facility fiscal year. A facility's twelve- (12-) month fiscal reporting period. If the facility is also participating in the Title XVIII Medicare (Medicare) program, the Medicaid cost report period shall be the same as the Medicare cost report period. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

(EE) Facility size. The number of licensed nursing facility beds as determined from the cost report.

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

(GG) 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.

(HH) Hospital based. Any nursing facility bed licensed and certified which is physically connected to or located in a hospital.

(II) 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, and ninety-five percent (95%) of the median per diem for the capital 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 July 1, 2022 for the initial 2019 rate base year;

(JJ) Licensed bed. Any skilled nursing facility or intermediate care facility bed meeting the licensing requirement of the Missouri Department of Health and Senior Services.

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(KK) Minimum Data Set (MDS). A standardized, primary and comprehensive tool used to assess a patient's functional, medical, psychosocial, and cognitive status for residents of nursing facilities to participate in Medicare and Medicaid.

(LL) Minimum utilization days. Calculated number of patient days, based on the minimum utilization percentage, which will be used in the determination of the facility's administration and capital cost component per diems if the facility's occupancy is below the minimum utilization percent set forth in subsection (7)(N). Minimum utilization days are calculated by multiplying the facility's bed days by the minimum utilization percent set forth in subsection (7)(N).

(MM) Miscellaneous discounts/other revenue deductions. A contra revenue account to reduce 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.

(NN) Median. The middle value in a distribution, above and below which lie an equal number of values. The distribution for purposes of this plan 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)(N) by dividing the facility's allowable costs by the greater of the facility's actual patient days or the calculated minimum utilization days.

(OO) Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2). Guidelines and policies to implement Medicare (Title VIII) regulations which set forth principles for determining the reasonable cost of provider services.

1. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this plan as published by the Centers for Medicare & Medicaid Services (CMS) at its website <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021929> and <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals-Items/CMS021935>.

2. The federal regulations 42 CFR 413 forming the basis of the Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) is incorporated by reference and made a part of this plan as published by CMS at its website <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-413?toc=1>.

3. The Medicare Provider Reimbursement Manual (CMS Publications 15-1 and 15-2) shall be referred to as the Medicare PRM throughout this plan.

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(PP) 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.

1. HIV nursing facility. A nursing facility that operates exclusively for persons with the human immunodeficiency virus (HIV) that causes acquired immunodeficiency syndrome (AIDS) and that was granted an exemption from Certificate of Need under section 197.316, RSMo.

2. New MO HealthNet nursing facility. A qualified facility not previously certified for participation in the Medicaid Program within the last twenty-four (24) months. A new MO HealthNet nursing facility shall be given an interim reimbursement rate until a prospective rate is established on its rate setting cost report. A facility previously Medicaid certified within the last twenty-four (24) months (i.e., a facility that terminated participation in the MO HealthNet program and subsequently re-enrolled in the MO HealthNet program) is not considered to be a new MO HealthNet nursing facility regardless of any changes, including, but not limited to, a change of ownership, change of operator, tax identification change, merger, bankruptcy, name change, address change, payment address change, Medicare number change, National Provider Identifier (NPI) change, or facilities/offices that have been closed and reopened at the same or different locations. A replacement facility, whether it is at the same location or a different location, and whether the Medicare number is retained or if a new Medicare number is issued, is not considered to be a new MO HealthNet nursing facility. These facilities shall be given the prospective rate they had prior to terminating from the MO HealthNet program, plus any applicable adjustments set forth in the plan between the termination date and the re-certification date.

(QQ) Occupancy rate. The occupancy rate is the percentage of a facility's capacity that is occupied by patients. This may also be referred to as occupancy, utilization, or utilization rate.

1. Total occupancy rate. A facility's total actual patient days divided by the total bed days for the same period as determined from the cost report. For a distinct part facility that only has part of its total licensed beds certified for participation in the MO HealthNet program and that completes a worksheet one (1) of the cost report, the occupancy rate is determined by dividing the total actual patient days from the certified portion of the facility by the total bed days from the certified portion for the same period from the cost report.

2. Medicaid occupancy rate. A facility's Medicaid patient days divided by the total patient days for the same period as determined from the cost report.

(RR) Patient care. This cost component includes costs reported in the cost report on lines 46-70.

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(SS) 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). The day of discharge is not a patient day for reimbursement unless it is also the day of admission.

(TT) Per diem. The daily rate calculated using this plan's cost components and used in the determination of a MO HealthNet facility's prospective and/or interim rate.

(UU) Provider or facility. A nursing facility or HIV nursing facility with a valid Medicaid participation agreement with the Department of Social Services for the purpose of providing nursing facility or HIV nursing facility services to Title XIX-eligible participants.

(VV) Prospective rate. The MO HealthNet reimbursement rate determined from the rate setting cost report.

(WW) Rate setting period or rate base year. The period in which a facility's MO HealthNet'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 or rate base year cost report.

(XX) Reimbursement rate. A prospective or interim rate.

(YY) 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 plan, 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—

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(I) Has an ownership interest totaling 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.

(ZZ) 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.

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

(BBB) 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 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) Supplies, items, and services required by federal or state law or regulation that must be provided by nursing facilities participating in the Title XIX program;

(B) Room and board. A private room must be provided, at no additional charge, if it is necessary to isolate a participant due to a medical or social condition, examples of which may be contagious infection or loud irrational speech;

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(C) Temporary leave of absence days for Medicaid 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 participant's plan of care and prescribed by a physician. Periods of time during which a participant is away from the facility visiting a friend or relative are therapeutic home leave days and considered temporary leaves of absence. Hospital leave days, as defined in 13 CSR 70-10.070, are also considered temporary leaves of absence and each hospital leave day is counted as two (2) temporary leave of absence days in determining the twelve (12) allowable leave days for each six (6) month period described above;

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

(E) All laundry services, including personal laundry;

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

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

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

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

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

(K) All non-legend antacids, non-legend laxatives, non-legend stool softeners, and non-legend vitamins. Providers may not elect which non-legend 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.

(6) Non-covered Supplies, Items, and Services. Non-covered supplies, items, and services include, but are not limited to, the following:

(A) Supplies, items, and services which are not covered in a facility's reimbursement rate;

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

(C) Supplies, items, and services that are billable to Medicare or other third-party payer; and

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

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(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area. Reasonableness 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 plan, 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 plan. Compensation must be paid (whether in cash, negotiable instrument, or in kind) within seventy-five (75) days after the close of the cost report period in accordance with the guidelines published in the Medicare PRM, Part 1, Section 906.4.

(B) Covered supplies, items, and services as defined in section (5) of this plan.

(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 plan, 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 that are a necessary part of the operation of a nursing facility and are limited as follows: 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. Vehicles subject to the limit include cars, trucks, vans, sport utility vehicles (SUVs), and shuttle buses. Golf carts, utility terrain vehicles (UTVs), all terrain vehicles (ATVs), and other vehicles not aforementioned in this subsection shall not be included in the total vehicle count for the limit. If the number of vehicles exceeds the limit, the oldest vehicle(s) based on the date the facility acquired the vehicle(s), and the associated costs, are allowable. Costs related to vehicles that are disallowed shall also be disallowed and adjustments made accordingly.

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1. Depreciation.

A. An appropriate allowance for depreciation on allowable vehicles is reported 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 134 of CR (3-95).

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

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

5. Personal property taxes. Personal property taxes related to allowable vehicles shall be reported 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 135 of CR (3-95).

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(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 107 of CR (3-95).

2. Other insurance. Liability, umbrella, and other general insurance for the nursing facility should be reported on 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) 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), and (G). Lease expenses shall be reported on line 103 of the CR (3-95). A facility operating its building under a capital 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.

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

(H) Value of Services of Employees.

1. Except as provided for in this plan, 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.

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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.

(I) 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.

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(J) 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 which the facility may be reimbursed for under 13 CSR 70-10.120 Reimbursement for Nurse Assistant Training.

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

(K) 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.

(L) 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.

(M) 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.

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(N) Minimum Utilization. In the event the occupancy rate of a facility is below eighty percent (80%), the administration and capital cost components will be adjusted as though the provider experienced eighty percent (80%) 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 percent (80%), the total allowable costs are divided by the minimum utilization days rather than the facility's actual patient days. In no case may costs disallowed under this provision be carried forward to succeeding periods.

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

(P) 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 51 of CR (3-95).

(Q) 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.

(R) 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 plan;

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(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, owners, and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(O) Non-covered supplies, items, and services as defined in section (6);

(P) Owner's compensation in excess of the applicable range of administrative salaries paid to individuals other than owners for proprietary and non-proprietary providers and based upon the total number of working hours.

1. Following is the division's 2019 Owner Compensation Guidelines. The division's 2019 Owner Compensation Guidelines shown below shall be updated annually using the CMS Market Basket Index for Wages (i.e., *IHS Markit / Healthcare Cost Review* publication, "Table 6.7 CMS Nursing Home without Capital Market Basket," and the "Wages - %MOVAVG" index).

| Owner Compensation Guidelines | | | | |
|-------------------------------|-----------|--------|---------|--------|
| Year | Bed Size | Low | High | Median |
| 2019 | 0 - 74 | 55,917 | 100,415 | 71,552 |
| | 75 - 99 | 42,080 | 102,208 | 72,151 |
| | 100 - 149 | 60,132 | 121,451 | 78,162 |
| | 150 - 200 | 62,536 | 122,652 | 96,202 |
| | 200+ | 72,151 | 180,379 | 99,203 |

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2. The applicable range will be determined as follows:

A. Number of licensed beds owned or managed; and

B. 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.

3. 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 supplies, items, 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 non-routinely 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 which the facility may be reimbursed for under 13 CSR 70-10.120 Reimbursement for Nurse Assistant Training; and

(Z) Losses from disposal of assets.

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(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 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.

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(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.

1. Each provider shall adopt the same twelve- (12-) month fiscal period for completing its Medicaid cost report as is used for its Medicare cost report, if the facility also participates in the Medicare program. If the provider does not participate in Medicare, the Medicaid cost report should have the same twelve- (12-) month fiscal year consistent with the facility's accounting and reporting period.

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

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

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.

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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 if there has been an extension granted for its Medicare cost report, if applicable, or 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 may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this plan, 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 or its authorized contractor. 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 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 authorized contractor;

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

H. Management contracts;

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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 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 is not required for the following:

A. Hospital based 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.

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.

C. New MO HealthNet facility or Re-certified MO HealthNet facility. The first (1st) cost report for a new facility enrolled in the MO HealthNet program or a facility that had terminated from participation in the MO HealthNet program and was re-certified in the MO HealthNet program may not be required if it is a short period cost report. A short period cost report covers three (3) months or less of nursing facility services for MO HealthNet participants, relative to the facility's fiscal year.

(I) If the provider participates in the Medicare program, the provider must complete the MO HealthNet cost report covering the same period as the Medicare cost report unless a short period cost report would still be required by Medicare but is not required by MO HealthNet because it covers three (3) months or less. For example:

(a) Example A: A facility enters the Medicaid/Medicare program on December 20 and has a December 31 fiscal year end. If Medicare requires that the December 20 – December 31 period be combined with the subsequent year cost report, then the MO HealthNet cost report should cover the same period.

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(b) Example B: A facility enters the Medicaid/Medicare program on October 20 and has a December 31 fiscal year end. If Medicare requires that a cost report be submitted for October 20 through December 31, the facility may request that the division waive that cost report for MO HealthNet since it is within the three (3) month short period. The division must approve the request to waive the cost report.

(II) If the facility does not participate in Medicare, the facility must contact the division regarding the treatment of the short period cost report and the division must approve such treatment. The provider may:

(a) Submit the short period cost report; or

(b) Combine the short period with the cost report for the subsequent year; or

(c) Choose not to submit information relating to the short period either on a stand-alone cost report basis or combined with the subsequent year cost report.

11. Notification of change in provider status and withholding of funds for a change in provider status. A provider shall notify the Institutional Reimbursement Unit of the division via email at IRU.NursingFacility@dss.mo.gov prior to a change of control, ownership, or termination of participation in the MO HealthNet program. 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 may withhold funds from the old/terminating provider's remaining payments for any amounts owed to the division, including but not limited to, unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the provider owes, the division may withhold that amount from the old/terminating provider's remaining payments. If the division cannot determine the amount a provider owes, it may withhold a minimum of thirty thousand dollars (\$30,000) of the remaining payments from the old/terminating provider. After six (6) months, any payments withheld will be released to the old/terminating provider, less any amounts owed to the division, including but not limited to, unpaid NFRA, overpayments, and system claim adjustment credits; or

B. If the division does not receive notification prior to a change of control or ownership, the division may withhold funds from the provider identified in the current MO HealthNet participation agreement for any amounts owed to the division from the old/terminating provider, including but not limited to, unpaid NFRA, overpayments, and system claim adjustment credits. If the division can determine the amount the old/terminating provider owes, the division may withhold that amount from the current provider's payments. If the division cannot determine the amount the old/terminating provider owes, it may withhold a minimum of thirty thousand dollars (\$30,000) of the next available MO HealthNet payment from the provider identified in the current MO HealthNet participation agreement. If the MO HealthNet payment is less than thirty thousand dollars (\$30,000), the entire payment will be withheld. 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, including but not limited to unpaid NFRA, overpayments, and system claim adjustment credits.

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(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 and federal law.

Certification of Officer or Administrator of Provider

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) 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.

| | |
|------------------------------------|-----------------------------|
| _____ | _____ |
| <i>Notary Public</i> | <i>Authorized Signature</i> |
| | _____ |
| | <i>(Title)</i> |
| <i>My Commission Expires</i> _____ | _____ |
| | <i>(Date)</i> |

(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 plan, including reasonable requests by the division or its authorized contractor for additional information.

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

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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 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 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 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 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 MO HealthNet 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 MO HealthNet 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 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 full twelve- (12-) month cost report.

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(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 own, control, or manage 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 plan, 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 plan.

(11) Prospective Rate Determination. The division will use the rate setting cost report described in (11)(I) to determine the nursing facility's prospective rate, as detailed in (11)(A)-(I) below.

(A) Patient Care. Each nursing facility's patient care per diem shall be calculated as follows –

1. The base patient care per diem shall be the lower of the —

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

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

2. The base patient care per diem determined in (11)(A)1. shall be adjusted by the facility's average Medicaid CMI using the RUGS IV 48 group model classification system from the two (2) preceding quarterly calculations relative to the effective date of the rate (i.e., for 2019 rebase rates effective July 1, 2022, the January 1, 2022 and April 1, 2022 CMI calculations shall be used) and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate.

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3. Following is an illustration of the calculation of the patient care per diem:

| Description | Total Allowable Cost | Ceiling | Lower of Ceiling / Per Diem |
|--|----------------------|----------|-----------------------------|
| Total Patient Care Costs | \$3,285,275 | | |
| Aides & Orderlies | \$918,303 | | |
| Dietary Salaries | \$248,776 | | |
| Total | \$1,167,079 | | |
| Salary Adjustment | 2% | \$23,342 | |
| Adjusted Patient Care | \$3,308,617 | | |
| Trend | 7.69% | | |
| Trended Cost | \$3,563,050 | | |
| Statewide Average Total CMI | .8744 | | |
| Cost Report Total CMI | .9664 | | |
| Total CMI Adjusted Costs (\$3,563,050*.8744/.9664) | \$3,223,852 | | |
| Total Patient Days | 30,475 | | |
| Base Patient Care Per Diem | \$105.79 | \$127.12 | \$105.79 |
| Medicaid CMI | .8206 | | |
| Medicaid CMI Adjusted Patient Care Per Diem (\$105.79*.8206/.8744) | | | \$99.28 |

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(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 adjustments and trends; or

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

3. Following is an illustration of the calculation of the ancillary per diem:

| Description | Total Allowable Cost | Ceiling | Lower of Ceiling / Per Diem |
|--------------------------|----------------------|---------|-----------------------------|
| Total Ancillary Costs | \$454,281 | | |
| Laundry Salaries | \$58,002 | | |
| Housekeeping Salaries | \$137,329 | | |
| Beauty & Barber Salaries | \$0 | | |
| Total | \$195,331 | | |
| Salary Adjustment | 2% | \$3,907 | |
| Adjusted Patient Care | \$458,188 | | |
| Trend | 7.69% | | |
| Trended Cost | \$493,423 | | |
| Total Patient Days | 30,475 | | |
| Ancillary Per Diem | \$16.19 | \$21.48 | \$16.19 |

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(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)(N); 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)(N).

3. Following is an illustration of the calculation of the administration per diem:

| Description | Total Allowable Cost | Ceiling | Lower of Ceiling / Per Diem |
|--|----------------------|---------|-----------------------------|
| Total Administration Costs | \$1,772,163 | | |
| Trend | 7.69% | | |
| Trended Cost | \$1,908,442 | | |
| Total Patient Days | 30,475 | | |
| Minimum Utilization Days | 44,384 | | |
| Greater of Total Patient Days or Min. Utilization Days | 44,384 | | |
| Administration Per Diem | \$43.00 | \$35.73 | \$35.73 |

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(D) Capital. Each nursing facility's capital per diem shall be determined using the fair rental value system (FRV), which consists of two (2) elements — rental value 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.–3.

1. Rental value.

A. Determine the total asset value.

(I) Determine facility size from the rate setting cost report. The changes in the number of licensed beds (i.e., increase and decreases) from the date the facility was originally licensed through the end of the rate setting cost report period should be determined and should result in the same number of licensed beds at the end of the facility's rate setting cost report.

(II) Determine the bed equivalency for capital expenditures from the date the facility was originally licensed through the end of the rate setting cost report period by taking the cost of the capital expenditures for each year divided by the asset value per bed for the year of the capital expenditures rounded down to the nearest whole bed. The cost of the capital expenditures must be at least the asset value per bed for the year of the capital expenditures for each bed equivalency. For example, a capital expenditures done in 2009 with a cost of two hundred seventy thousand dollars (\$270,000) is equal to five (5) beds. ($\$270,000/\$47,948$ equals 5.65 beds rounded down to 5 beds).

(III) The Total Facility Size is the sum of (I) and (II).

(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 rate base year. The age of bed equivalencies for capital expenditures is calculated by subtracting the year the capital expenditures were made from the year relative to the rate base year. The age of the beds for multiple licensing dates (i.e., for increases and decreases in licensed beds) and multiple bed equivalencies is calculated on a weighted average method rounded to the nearest whole year. For licensed bed decreases and replacement beds, the oldest beds are delicensed first. 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%).

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 six and three hundred seventy fifths percent (6.375%) to determine the rental value. The six and three hundred seventy fifths percent (6.375%) is comprised of two and one-half percent (2.5%), which is based on a forty- (40-) year life, plus three and eight hundred seventy fifths percent (3.875%) for a return. The three and eight hundred seventy fifths percent (3.875%) is based on the Treasury Bill thirty- (30-) year coupon rate in effect as of January 1, 2022 of one and eight hundred seventy fifths percent (1.875%) plus two percent (2%).

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

(I) The following is the determination of the total facility size and the age of the beds:

Historical Base Data *

| | Total Facility Size | Age | Age x Beds |
|-----------------|------------------------|-----|------------|
| Licensed Beds | 75 | | |
| Bed Equivalents | 0 | | |
| Totals | <u>75</u> | 30 | 2,250 |

* This is the cumulative, historical data previously used to determine existing nursing facilities' prospective rates under 13 CSR 70-10.015.

Licensure History *

| | Licensure Year | No. of Bed Incr/(Decr) | Age From 2019 | Age x Beds |
|---|----------------|---------------------------|------------------|------------|
| Bed Increases / Decreases: | 2003 | 15 | 16 | 240 |
| | 2004 | 5 | 15 | 75 |
| | 2006 | 10 | 13 | 130 |
| | 2008 | (5) | 11 | (55) |
| Totals (Bed Incr/(Decr thru 2019)) | | <u>25</u> | | <u>390</u> |
| Total Licensed Beds (Base Data + Bed Incr/(Decr)) | | 100 | | |

* This is the licensure history from 2002-2019 which reflects the licensure changes subsequent to the Historical Base Data shown above.

Capital Expenditure History *

| Year | Allowable Capital Expenditures for Bed Equip | Asset Value – Year of Capital Expenditures | Bed Equivalents | Age From 2019 | Age x Beds |
|--|---|--|--------------------|------------------|------------|
| 2002 | \$1,677,164 | \$35,325 | 47 | 17 | 799 |
| 2009 | 170,824 | 47,948 | 3 | 10 | 30 |
| 2014 | 310,351 | 52,042 | 5 | 5 | 25 |
| 2018 | 84,308 | 53,769 | 1 | 1 | 1 |
| 2019 | 145,692 | 64,701 | 2 | 0 | 0 |
| Totals (Bed Equiv. thru 2019) | | | <u>58</u> | | <u>855</u> |
| Total Bed Equiv. (Base Data + Bed Equiv thru 2019) | | | 58 | | |

* This is the capital expenditure and bed equivalency history from 2002-2019 which reflects the changes subsequent to the Historical Base Data shown above.

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Total Facility Size and Weighted Average Age

| | | |
|--|-----|-------|
| Total Facility Size (Licensed Beds + Bed Equiv.) | 158 | 3,495 |
| Weighted Average Age (3,495 / 158) | | 22 |

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

| | |
|----------------------|---------------------|
| Total facility size | 158 |
| x Asset value - 2019 | \$64,701 |
| Total asset value | <u>\$10,222,758</u> |

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

| | |
|-------------------------------|----------------------|
| Total asset value | \$10,222,758 |
| x Age of beds x 1% | 22% |
| - Reduction for age (max 40%) | <u>(\$2,249,007)</u> |
| Facility asset value | <u>\$7,973,751</u> |

(IV) Rental value is the facility asset value multiplied by 6.375%.

| | |
|------------------------|------------------|
| Facility asset value | \$7,973,751 |
| x Rental value percent | x 6.375% |
| Rental value | <u>\$508,327</u> |

2. Pass-through expenses.

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

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

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3. Capital component per diem calculation. A per diem is calculated for each element detailed above in paragraphs (11)(D)1.–2. which are then added together to determine the total capital cost component per diem.

A. Rental value per diem. A per diem is calculated by dividing the rental value 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.(III) multiplied by three hundred sixty-five (365) adjusted by the greater of the minimum utilization as determined in subsection (7)(N) or the facility's occupancy from the rate setting cost report. The following is an illustration of how the rental value per diem is calculated:

| | Allowable Cost | Computed Patient Days * | Per Diem |
|--------------------------|-------------------|----------------------------|----------|
| Rental Value | \$508,327 | 46,136 | \$ 11.02 |
| * Computed Patient Days: | | | |
| Total facility size | | 158 | |
| x 365 days | | x 365 | |
| Subtotal | | <u>57,670</u> | |
| Greater of: | | | |
| Minimum Utilization | 80.00% | | |
| Facility Occupancy ** | 56.63% | x 80.00% | |
| Computed Patient Days | | <u>46,136</u> | |

** Assumption: facility occupancy from the rate setting cost report = 56.63%

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B. Pass-through expenses per diem. A per diem is calculated by dividing the pass-through expenses by the greater of the minimum utilization days as determined in subsection (7)(N) or the facility's patient days from the rate setting cost report, rounded to the nearest cent. The following is an illustration of how the pass-through per diem is calculated:

| | Allowable Cost | Patient Days * | Per Diem |
|-------------------------------------|-------------------|-------------------|----------|
| Pass-Through Expenses: | | | |
| Property Insurance | \$23,969 | | |
| Real Estate Taxes | 61,962 | | |
| Personal Property Taxes | 3,408 | | |
| Total Pass-Through Expenses | 89,339 | | |
| Trend | 7.69% | | |
| Total Trended Pass-Through Expenses | 96,209 | 43,050 | \$2.23 |
| * Patient days - Greater of: | | | |
| a. Facility patient days | | 30,475 | |
| b. Minimum utilization days | | | |
| Beddays | | 53,812 | |
| x Minimum Utilization Percent | | x 80% | |
| Minimum utilization days | | 43,050 | |

C. The capital cost component per diem is the sum of the per diems determined in subparagraphs (11)(D)3.A. and B.

| | |
|---------------------------------------|----------------|
| Rental value | \$11.02 |
| Pass-through expenses | \$2.23 |
| Total capital cost component per diem | <u>\$13.25</u> |

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

| Cost Component | Per Diem |
|-------------------------------|-----------------|
| Patient Care | \$99.28 |
| Ancillary | \$16.19 |
| Administration | \$35.73 |
| Capital (FRV) | \$13.25 |
| Total Cost Component Per Diem | <u>\$164.45</u> |

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(F) Special Per Diem 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 July 1, 2022, shall receive a per diem adjustment equal to four and seventy-fifth percent (4.75%) of the facility's patient care per diem determined in subsection (11)(A) 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. Multiple component incentive. Each facility with a prospective rate on or after July 1, 2022, 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 (11)(B), is greater than or equal to seventy percent (70%), rounded to four (4) decimal places (.6985 would not receive the adjustment), of the facility's total per diem, the adjustment is as follows:

| Patient Care & Ancillary Percent of Total Rate | Incentive |
|---|-----------|
| < 70% | \$0.00 |
| > or = 70% but < 75% | \$0.10 |
| > or = 75% but < or = 80% | \$0.15 |
| > 80% | \$0.20 |

B. A facility shall receive an additional incentive if it receives the adjustment in subparagraph (11)(F)2.A. and if the facility's Medicaid utilization percent is greater than eighty-five percent (85%), rounded to four (4) decimal places (.8485 would not receive the adjustment). The adjustment is as follows:

| Medicaid Utilization Percent | Incentive |
|------------------------------|-----------|
| < 85% | \$0.00 |
| > or = 85% but < 90% | \$0.10 |
| > or = 90% but < 95% | \$0.15 |
| > or = 95% | \$0.20 |

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3. Value Based Purchasing (VBP) Incentive. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. The facility shall receive a per diem adjustment for each Quality Measure (QM) Performance threshold that it meets, up to a maximum per diem adjustment of seven dollars (\$7.00). The threshold for each QM is based on national cut-points used by CMS in its Five Star Rating System. Each threshold is the maximum QM value a facility can have in order to receive the per diem adjustment. These thresholds are listed in Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017. Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017 is incorporated by reference and made a part of this plan as published by CMS and available at <https://myersandstauffer.com/client-portal/missouri/>.

(I) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022 is used to determine the per diem adjustment(s) the facility qualified to received for the rates effective July 1, 2022.

(II) The QM Performance Measure threshold and per diem adjustments are as follows:

| QM Performance | Threshold | Per Diem Adjustment |
|--|-----------|---------------------|
| Decline in Late-Loss ADLs | <= 10.0% | \$1.00 |
| Decline in Mobility on Unit | <= 8.0% | \$1.00 |
| High-Risk Residents w/ Pressure Ulcers | <= 2.7% | \$1.00 |
| Anti-psychotic Medications | <= 6.8% | \$1.00 |
| Falls w/ Major Injury | <= 1.3% | \$1.00 |
| In-dwelling Catheter | <= 1.1% | \$1.00 |
| Urinary Tract Infection | <= 1.9% | \$1.00 |

B. A VBP percentage will also be applied to the per diem adjustment for each facility that qualifies for a VBP Incentive. The VBP percentage will be determined by the total QM score calculated from the Five-Star Rating System scores for each of the QMs, as follows:

(I) The facility's most current twelve- (12-) month rolling average QM value as of January 21, 2022 is used to determine the facility's QM Score and VPB Percentage;

(II) For each QM value, the corresponding number of QM points will be determined from Table A3 of the Five-Star Quality Rating System: Technical Users' Guide dated January 2017;

(III) The QM points for all of the QMs will be summed to determine the facility's total QM Score.

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(IV) The VBP percentage for each scoring range is listed in the following table.

| QM Scoring Tier | Minimum Score | VBP Percentage |
|-----------------|---------------|----------------|
| 1 | 600 | 100% |
| 2 | 520 | 75% |
| 3 | 440 | 50% |
| 4 | 360 | 25% |
| 5 | 0 | 0% |

4. Mental Illness Diagnosis Add-On. Each facility with a prospective rate on or after July 1, 2022, and which meets the following criteria shall receive a per diem adjustment:

A. If at least forty percent (40%) of a facility's Medicaid participants have the following mental illness diagnosis, the facility shall receive a per diem adjustment of five dollars (\$5.00):

(I) Schizophrenia

(II) Bi-polar

(G) Prospective Rate Calculation.

1. A preliminary per diem shall be calculated and is the sum of:

A. The cost component per diems as set forth in (11)(A)-(11)(E), plus

B. The patient care incentive and multiple component incentive set forth in (11)(F)1. and (11)(F)2., respectively.

2. A base rate shall be determined and is the greater of:

A. The preliminary per diem, and

B. The facility's prospective rate as of June 30, 2022, excluding NFRA.

3. The facility's rebased rate shall be the sum of:

A. The facility's base rate, plus

B. The NFRA in effect for the applicable date of service.

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4. The facility's prospective rate shall be the sum of:
- A. The facility's rebased rate, plus
 - B. The VBP Add-On set forth in (11)(F)3., if applicable, plus
 - C. The Mental Illness Diagnosis Add-On set forth in (11)(F)4., if applicable.
5. The following is an illustration of how subsections (11)(A)–(G) determine a facility's prospective rate:

| Cost Component | Per Diem |
|---|----------|
| Patient Care | \$99.28 |
| Ancillary | \$16.19 |
| Administration | \$35.73 |
| Capital (FRV) | \$13.25 |
| Total Cost Component Per Diem | \$164.45 |
| Patient Care Incentive | \$5.03 |
| Multiple Component Incentive | \$0.10 |
| Total Patient Care & Multiple Component Incentives | \$5.13 |
| Preliminary Per Diem | \$169.58 |
| Current Prospective Rate (excluding NFRA) – June 30, 2022 | \$163.98 |
| Base Rate - Greater of Preliminary Per Diem or June 30, 2022 Prospective Rate | \$169.58 |
| NFRA – July 1, 2022 | \$12.93 |
| Total Rebased Rate | \$182.51 |
| VBP Incentive | \$2.00 |
| VBP Payment Percent | 75% |
| VBP Add-On Per Diem Rate | \$1.50 |
| Mental Illness Diagnosis Add-On | \$0.00 |
| Total Prospective Rate – July 1, 2022 | \$184.01 |

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(H) Semi-Annual and Annual Rate Updates. Each facility with a prospective rate on or after July 1, 2022 shall have its rate updated for the following items as described below:

1. Semi-Annual Acuity Adjustment for Patient Care Per Diem Rate. Each facility's patient care per diem rate will be adjusted semi-annually using a current Medicaid CMI. The patient care per diem rate will be adjusted effective for dates of service beginning January 1 and July 1 of each year. The Medicaid CMI will be updated based on the facility's average Medicaid CMI using the RUGS IV 48 group model classifications from the two (2) preceding quarterly calculations. The allowable patient care cost per day determined in (11)(A)1. shall be adjusted by the applicable Medicaid CMI and shall be the facility's patient care per diem to be included in the facility's total prospective per diem rate, effective each January 1 and July. The patient care and multiple component incentives will not be updated based on the adjusted patient care per diem. The facility's prospective rate shall continue to include the patient care and multiple component incentives initially determined for the prospective rate. The applicable Medicaid CMI are as follows:

A. Effective for dates of service beginning January 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding July 1 and October 1 quarterly Medicaid CMI calculations.

B. Effective for dates of service beginning July 1 of each year, each facility's Medicaid CMI will be updated using the average of the preceding January 1 and April 1 quarterly Medicaid CMI calculations.

2. Semi-Annual Adjustment for VBP Incentive. Each facility's QM Performance data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The VBP will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The QM Performance data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. A facility must meet the criteria set forth in (11)(F)3. each period and will lose any per diem adjustments for which it does not continue to qualify.

3. Semi-Annual Adjustment for Mental Illness Diagnosis Add-On. Each facility's Mental Illness Diagnosis data shall be re-evaluated semi-annually and the per diem add-on rate shall be adjusted accordingly. The Mental Illness Diagnosis will be recalculated effective for dates of service beginning January 1 and July 1 of each year. The Mental Illness Diagnosis data will be updated based on the most current data available as of November 15 for the January 1 rate adjustment and as of May 15 for the July 1 rate adjustment. A facility must meet the criteria set forth in (11)(F)4. each period and will lose any per diem adjustments for which it does not continue to qualify.

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4. Annual Capital Rate Update. Each facility's capital rate will be recalculated annually by updating the rental value portion of the capital rate. The capital rate will be recalculated at the beginning of each state fiscal year (SFY), effective for dates of service beginning July 1, as follows:

A. The total facility size will be updated each year for any increases or decreases in licensed beds and capital expenditures that qualify as bed equivalencies, as follows:

(I) For SFY 2024, effective for dates of service beginning July 1, 2023, the total facility size will be updated using information from the 2020 and 2021 cost reports.

(II) For SFY 2025 forward, the total facility size will be updated using the information from the third (3rd) prior year cost report relative to the SFY (i.e., for SFY 2025, the facility size will be updated using 2022 cost report data.)

B. The weighted average age of the facility shall be updated each year. The age shall be calculated from the year coinciding with the latest cost report used to update the facility size above in A. (i.e., the age for SFY 2024 shall be calculated from 2021, the age for SFY 2025 shall be calculated from 2022, etc.)

C. The asset value shall be updated each SFY. The asset value shall be updated for the year coinciding with the latest cost report used to update the facility size above in A. (i.e., for SFY 2024 the 2021 asset value shall be used, for SFY 2025 the 2022 asset value shall be used, etc.).

5. A facility's prospective rate shall be increased or decreased based upon the semi-annual and annual rate adjustments but the rate shall not be decreased below the facility's June 30, 2022 prospective rate.

(I) Rate Setting Cost Report.

1. A facility with a valid Medicaid participation agreement and a prospective rate in effect on June 30, 2022, shall have its prospective rate rebased on its 2019 cost report. If a facility does not have a 2019 cost report, the next available cost report year shall be used as the rate setting cost report.

2. A nursing facility never previously certified for participation in the MO HealthNet program that originally enters the MO HealthNet program after June 30, 2022, shall receive an interim rate, as defined in subsection (4)(JJ), effective on the initial date of MO HealthNet certification. A prospective rate shall be determined in accordance with this plan from the 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. This prospective rate shall be retroactively effective to the first day of the facility's second full twelve- (12-) month fiscal year and shall replace the interim rate for dates of service beginning on the first day of the facility's second full twelve- (12-) month fiscal year. The following items shall be updated annually and shall be used in determining the prospective rate:

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A. Ceilings. The patient care, ancillary, and administration cost component ceilings shall be updated for any global per diem adjustments as set forth in (12)(A). The effective date of the updated ceilings shall be the effective date of the global per diem adjustment. The ceiling used to determine the prospective rate shall be the ceiling in effect at the beginning of the rate setting period.

B. Asset Value. The asset value shall be updated annually as set forth in (4)(E). The asset value for the year coinciding with the rate setting cost report year (i.e., the end of the cost report period) shall be used.

C. Age of Beds and Bed Equivalencies. The age of beds shall be calculated by subtracting the year the beds were originally licensed from the year coinciding with the rate setting cost report year (i.e., the end of the cost report period). The age of bed equivalencies shall be calculated by subtracting the year the capital expenditures were made from the year coinciding with the rate setting cost report (i.e., the end of the rate setting cost report period).

3. A facility with a valid Medicaid participation agreement in effect after June 30, 2022, which either voluntarily or involuntarily terminates its participation in the Medicaid Program and which reenters the Medicaid Program within two (2) years, 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 (12)(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.

(12) Adjustments to the Reimbursement. Subject to the limitations prescribed elsewhere in this plan, a facility's reimbursement rate may be adjusted as described in this section.

(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 this sub-section. Global per diem rate adjustments shall be allocated, and added to, the patient care, ancillary, and administration cost component ceilings based on the ceiling in effect at the time the global per diem adjustment is granted, unless the adjustment is directly attributable to a specific cost component(s). If the adjustment is directly attributable to a specific cost component(s), it shall be added to the specified cost component ceiling.

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(B) Extraordinary circumstances. A participating facility which has a prospective rate may request an adjustment to its reimbursement 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 reimbursement adjustment is sought. The dollar amount of the requested reimbursement 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 reimbursement 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 reimbursement adjustment. In the case of a reimbursement 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, reimbursement adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

1. 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;
2. Extraordinary circumstances, which are beyond the reasonable control of the nursing facility and are not a product or result of the negligence or malfeasance of the nursing facility, include, but are not limited to:
 - A. Unavoidable acts of nature that occur in a federally declared disaster area. Unavoidable acts of nature may include hurricane, flooding, earthquake, tornado, lightening, natural wildfire, or other natural disaster for which no one can be held responsible; or
 - B. Vandalism and/or civil disorder; and
3. Adjustment to a facility's reimbursement for extraordinary circumstances shall only be for costs that are not covered by insurance. The reimbursement adjustment(s) shall be calculated as follows:
 - A. For one- (1-) time costs that will not be incurred in future fiscal years —
 - (I) Costs directly associated with the extraordinary circumstances that have not been covered by insurance will be multiplied by the Medicaid occupancy percent from the latest cost report available for the time period preceding when the extraordinary circumstances occurred; and
 - (II) This amount will be paid to the facility as a one- (1-) time, lump sum payment.

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B. For ongoing costs that will be incurred in future fiscal years –

(I) Ongoing annual costs will be divided by the greater of:

(a) Annualized (calculated for a twelve- (12-) month period) total patient days from the latest cost report on file, or

(b) Minimum utilization days

(II) This calculation will be a per diem rate adjustment that will 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

C. For capitalized costs, the capital cost component per diem rate is updated at the beginning of each SFY so any capital expenditures resulting from the extraordinary circumstances will be captured during that annual rate update.

(C) 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 this plan.

(D) 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.

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(13) Exceptions.

(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. If the participant does not return to Missouri, the division shall withhold payments for nursing facility services, 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.
5. The Title XIX reimbursement rate for out-of-state providers shall be set as follows:
 - A. For out-of-state providers which provided services for Missouri Title XIX participants, the reimbursement rate shall be the lower of—
 - (I) 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

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(II) 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) Rate increases—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) Rate decreases—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.

(B) The Title XIX reimbursement rate for hospital based providers that provide services of less than one thousand (1,000) patient days for Missouri Title XIX 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 the patient care, ancillary, and administration cost components, plus the 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; and

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 plan; 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.

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(14) Sanctions and Overpayments.

(A) In addition to the sanctions and penalties set forth in this plan, 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.

(15) 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.

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

(17) Provider Participation. Payments made in accordance with the standards and methods described in this plan 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 plan at least to the extent these services are available to the general public.

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

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**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 rollabout

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**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

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