FILED
MAY - 5 2010
MISSISSIPPI
SECRETARY OF STATE

NOTICE OF RULE ADOPTION—FINAL RULE

STATE OF MISSISSIPPI
OFFICE OF THE GOVERNOR
DIVISION OF MEDICAID

Miss. Division of Medicaid
c/o Ginnie McCardle, Staff Officer
Walter Sillers Building
550 High Street
Suite 1000
Jackson, MS 39201-1399
(601) 359-6310
http://www.medicaid.ms.gov

Specific Legal Authority Authorizing the promulgation of Rule: Miss Code Ann. §43-13-121(1972), as amended §25-43-1.103(4)

Reference to Rules repealed, amended or suspended by the Proposed Rule :
MS State Plan Attachment 4.19-D (Entire Section)

Date Rule Proposed: February 8, 2010

Explanation of the Purpose of the Proposed Rule and the reason(s) for proposing the rule:
SPA2009-004 This State Plan amendment is being filed to make needed technical updates and corrections to the MS State Plan, Attachment 4.19-D. Technical corrections in this SPA will remove reference to outdated language, such as reference to Review Board that no longer exists, to revise the trend factor example to reflect updates caused by federal changes to the Consumer price indices, to remove working on incontinence supplies as mandated by CMS representatives, and to remove reference to cost report software that was abandoned. There is no expected fiscal impact as a result of this SPA, except for a nominal amount to be paid for feeding assistants training of possibly $100,000 in total funds per year.
The Agency Rule Making Record for this rule including any written comments received during the comment period and the record of any oral proceeding is available for public inspection by contacting the Agency at the above address.

☐ An oral proceeding was held on this rule:

Date:
Time:
Place:

☒ An oral proceeding was not held on this rule.

The Agency has considered the written comments and the presentations made in any oral proceedings, and

☐ This rule as adopted is without variance from the proposed rule.

☒ This rule as adopted differs from the proposed rule as there are minor editorial changes which affect the form rather than the substance of the rule.

☐ The rule as adopted differs from the proposed rule. The differences however are:
Within the scope of the matters in the Notice of Proposed Rule Adoption, the logical outgrowth of the contents of the Notice of Proposed Rule Adoption and the comments submitted in response thereto, and
The Notice of Proposed Rule Adoption provided fair warning that the outcome of the proposed rule adoption could be the rule in question.

The entire text of the Proposed Rule including the text of any rule being amended or changed is attached.

Effective Date of Rule: February 8, 2010

Executive Director
Signature and Title of Person Submitting Rule for Filing

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE RECIPIENTS

OF

LONG TERM CARE FACILITIES

TN NO 2009-004 DATE RECEIVED
SUPERSEDES DATE APPROVED 03-18-10
TN NO 79-06 DATE EFFECTIVE 02-08-10

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Introduction

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

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

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

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

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

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

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

CHAPTER 1

PRINCIPLES AND PROCEDURES

1-1 General Principles

A facility's direct care costs, therapy costs, care related costs, administrative and operating costs and property costs related to covered services will be considered in the findings and allocation of costs to the Medical Assistance Program for its eligible recipients. Costs included in the per diem rate will be those necessary to be incurred by efficiently and economically operated nursing facilities that comply with all requirements of participation in the Medicaid program with the exception of services provided that are reimbursed on a fee for service basis or as a direct payment outside of the per diem rate.

1-2 Classes of Facilities

Specific classes are used as a basis for evaluating the reasonableness of an individual provider's costs. The classes consist of Small Nursing Facilities (1 - 60 beds), Large Nursing Facilities (61 or more beds), Private Nursing Facilities for the Severely Disabled (PNFSD), Residential Psychiatric Treatment Facilities (PRTF), and Intermediate Care Facilities for the Mentally Retarded (ICF-MR).

1-3 Cost Reporting

A. Reporting Period

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

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

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

B. When to File

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

C. Extension for Filing

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

D. Delinquent Cost Reports

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

E. What to Submit

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

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

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

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

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

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

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

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

F. Where to File

The cost report and related information should be mailed to:

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

G. Cost Report Forms

All cost reports must be filed using forms and instructions that

are adopted by the Division of Medicaid.

H. Amended Cost Reports

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

I. Desk Reviews

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

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

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

The desk review procedures will consist of the following:

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

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

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

J. Audits of Financial Records

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

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

K. Record Keeping Requirements

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

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

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

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

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

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

available to the Division of Medicaid reviewers during the scheduled field visit, including any documentation relating to home office and/or management company costs. Records of a non-related management company will be made available to support the non-related party status of the management company.

The provider being audited is required to make available within the boundaries of the State of Mississippi, when it is reasonable to do so, all information required for the Division to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. When the Division of Medicaid concurs with the provider that it is not reasonable to make all necessary information available for review within the boundaries of the State of Mississippi (for example, when the records to be reviewed are too costly to ship compared to the costs of travel necessary travel will be paid by the division of Medicaid. However, if, in the opinion of the Division of Medicaid, the necessary information may be reasonably made available within the boundaries of the State of Mississippi and the provider being audited chooses not to make the necessary information available within the State's boundaries, the provider will bear all expenses and costs related to the audit, including, but not limited to travel and reasonable living expenses, and those costs will not be allowable on any subsequent cost report. Travel expenses and costs will include those allowed per policy issued by the Mississippi Department of Finance and Administration, Office of Purchasing and Travel for state employees traveling on official state business. The provider is required to make available to the Division of Medicaid reviewers, whenever possible, adequate space and privacy for the auditors to conduct the audit.

L. Failure to File a Cost Report

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

M. Change of Ownership

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

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

Facilities that undergo a change of ownership must file a cost report from the date of change of ownership through the end of the third month of ownership. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months.

The base rate of the old owner will be used to set the interim rate for the new owner, excluding hold harmless payment and return on equity. The provider may request and, absent any good cause to deny, the executive director shall approve setting the new owner's rate using the maximum per diem rate for the interim period. The maximum per diem rate is defined for a NF as the ceiling for direct care and care related costs, allocated between the two cost centers based on the cost report filed by the previous owner that was used to compute the rate in effect on the date of the change of ownership, and adjusted for the case mix of the previous owner for the appropriate calendar quarter, plus the ceiling for administrative and operating costs, plus the gross rental per diem payment computed under the fair rental system as defined by this plan. Quarterly rate adjustments will be made to adjust for changes in the case mix score. The maximum per diem rate is defined for an ICF-MR and PRTF as the ceiling for direct care, therapy, care related and administrative and operating costs, plus the gross rental per diem payment computed under the fair rental system as defined by this plan. Under the maximum rate, the new owner will not receive a return on equity capital per diem or a property tax and insurance per diem until the initial cost report is filed.

The new owner's interim rates will be adjusted retroactively based on the initial cost report, after desk review. The rates computed based on the initial cost report of the new owner will be effective the same date the change of ownership was effective.

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

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

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

N. Increase or Decrease in Number of Medicaid Certified Beds

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

will be revised whenever the number of Medicaid-certified beds changes, however, to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate.

Changes that either increase or decrease by one-third (1/3) or more the number of certified beds, must be approved effective the first day of a month. Facilities must file a cost report from the effective date of the increase or decrease of one-third (1/3) or more certified beds through the end of the third calendar month following the effective date of the increase or decrease. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than two (2) months or not more than four (4) months. These facilities must also file a cost report for the period from the date of the last cost report to the effective date of the increase or decrease in the number of beds that results in a change of one-third or more the number of certified beds.

Effective the date of the one-third (1/3) or more change, the interim per diem rate will be revised from the existing rate only to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate. Upon request, the facility's interim rate will also be revised to pay the ceilings for direct care and care related and administrative and operating costs. The facility's interim rates will be adjusted retroactively based on the initial cost report, after desk review. The rates computed based on the initial cost report of the facility will be effective beginning the same date the increase or decrease in the number of beds occurred.

O. New Providers

Nursing Facilities and ICF-MR's beginning operations during a reporting year will file an initial cost report from the date of certification to the end of the third (3rd) month of operation. The Division of Medicaid may lengthen the reporting period of the initial cost report to not more than six (6) months. PRTF's beginning operations during a reporting year will file a cost report from the date of certification to the end of the sixth (6th) month of operation. Facilities will be paid the maximum rate for their classification until the initial cost report is received and
the rate is calculated. The maximum rate for nursing facilities is

defined as the ceiling for direct care and care related costs paid based on a case mix of 1.000 plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. Quarterly rate adjustments will be made to adjust for changes in the case mix score, once available. The maximum rate for ICF-MR's and PRTF's is defined as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. New facilities will not be paid a return on equity per diem or a property tax and insurance per diem until the initial cost report is filed.

A retroactive rate adjustment to the initial certification date will be made based on the initial cost report, after desk review. Applicable facility-average case mix score(s) will be applied to nursing facility rates.

For example, a new nursing facility provider enrolls in the Medicaid program effective August 15, 2000. The facility’s interim per diem rate is set at the maximum rate for its classification, as defined above. The direct care and care related payment would equal the ceiling, due to use of a case mix score of 1.000. A cost report would be required for the period August 15, 2000 through October 31, 2000. The Division of Medicaid would issue a desk review after receipt and review of

the cost report. In addition, the Division of Medicaid would prepare an "Annual" case mix report to determine the case mix score for the cost report period. A "Quarter Final" case mix report would be prepared to determine the case mix score for each quarter beginning with the quarter July 1, 2000 through September 30, 2000. The facility's rates for the period August 15, 2000 through December 31, 2001 would be calculated using actual cost and census data from the August 15 through October 31 cost report, after desk review. The case mix reports would also be used in calculating the rates. The initial Quarter Final case mix score would be used for the rate periods beginning August 15, 2000; October 1, 2000; and January 1, 2000. The following quarters' rates would be set on the normal schedule using the quarter Final roster score from the second preceding quarter.

P. Out-of-State Providers

Nursing Facilities, PRTF's and ICF-MR's from states other than Mississippi may file claims for services provided to Mississippi Medicaid recipients that are

considered residents of Mississippi. These providers must provide documentation of their certification for Title XIX and the facility's Medicaid rate for the domicile state. In most cases, payment will be made based on the lesser of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification. The rates may be negotiated. However, the negotiated rate for ICF-MR's and PRTF's may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification. The negotiated rate for NF's may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for nursing facilities, as case mix adjusted. The maximum Mississippi Medicaid rate for out-of-state providers is defined for nursing facilities as the ceilings for direct care and care related costs paid based on a case mix of 1.000 plus the ceiling for administrative and operating costs and the gross rental per diem payment as computed under the plan. Classifications which have a case mix adjustment will be computed using a case mix score of 1.000 unless the facility submits an MDS form that is classifiable. The case mix adjustment will be applied to the maximum Mississippi Medicaid rate only when the maximum Mississippi Medicaid rate is determined to be lower than the Medicaid rate of the domicile state and when the Mississippi Medicaid rate is negotiated. The maximum Mississippi Medicaid rate for out-of-state providers is defined for ICF-MR's and PRTF's as the ceiling for direct care, therapies, care related, administrative and operating plus the gross rental per diem as computed under the plan. The maximum Mississippi Medicaid rate for out-of-state providers will not include a

return on equity per diem or a property tax and insurance per diem. The gross rental per diem used in determining the maximum rate will be based on submitted property information from the provider or a thirty year age in the absence of provider information.

Q. Change of Classification

Changes in the number of Medicaid certified beds resulting in a change of classification must be approved effective the first day of a month. Facilities that undergo a change of classification must file a cost report from the date of the change of classification through the end of the third month following the change. The Division of Medicaid may shorten or lengthen the reporting period of the initial cost report to not less than one (1) month or not more than four (4) months. Facilities must also file a cost report for the period from the last cost report period to the date of the change.

Effective the date of the change, the interim per diem rate will be changed from the existing rate to reflect the correct number of certified beds and to reflect the proper annualized patient days for the property and return on equity portions of the rate. In addition, the existing rate will be revised to apply the Administrative and Operating ceiling for the new classification. Upon request, the facility's interim rate will also be revised to pay the ceilings for direct care and care related and administrative and operating costs. The facility's interim rates will be adjusted retroactively based on the initial cost report,

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

1-4 Resident Fund Accounts

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

1-5 Admission, Transfer, and Discharge Rights

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

1-6 Payments to Providers

A. Acceptance of Payment

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

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

B. Assurance of Payment

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

C. Upper limit based on Customary Charges

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

D. Overpayments

An overpayment is an amount which is paid by the Division of Medicaid to a provider in excess of the amount that is computed in accordance with the provisions of this plan. Overpayments must be repaid to the Division of Medicaid within sixty (60) days after the date of discovery. Discovery occurs either (1) on the date the Division of Medicaid first notifies a provider in writing of an overpayment and specifies a dollar amount that is subject to recovery, or (2) on the date a provider acknowledges an overpayment to the Division of Medicaid in writing, whichever date is earlier. Failure to repay an overpayment to the Division of Medicaid may result in sanctions.

Overpayments documented in audits will be accounted for on the Form CMS-64 Quarterly Statement of Expenditures not later than the second quarter following the quarter in which the overpayment was found.

E. Underpayments

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

F. Credit Balances

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

1-7 Appeals and Sanctions

A. Appeal Procedures - Desk and Field Reviews

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

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

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

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

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

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

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

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

B. Grounds for Imposition of Sanctions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Sanctions

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

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

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

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

D. Disqualification from participation in the Medicaid Program.

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

1-8 Public Notification

1-8 Public Notification

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

1-9 Plan Amendments

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

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

1-10 Special Services

A. Swing Bed Services

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

reimbursement rate for swing-bed services will be the statewide average rate paid under the State Plan during the previous calendar year to Nursing Facilities.

The swing-bed provider will be responsible for collecting that portion of the total amount (days X rate) owed by the Medicaid recipient as indicated on the Division of Medicaid Form DOM-317. Hospitals operated in conjunction with a distinct part nursing facility will not receive swing-bed reimbursement for those patient days when empty distinct part long-term care beds are available. Hospitals may bill for those ancillary services rendered to swing-bed patients and not customarily furnished by nursing facilities such as a hospital outpatient claim or lab referral claim.

Cost Reporting. Swing-bed providers will not file separate cost reports required of other nursing facilities, nor will rates or amounts paid for swing-bed care be considered in the determination of nursing facility rates. In order to allocate

costs between hospital and swing-bed services in the participating provider's hospital cost report, the total reimbursement due for swing-bed patients will be subtracted from the hospital's total costs before determining allowable costs for routine hospital services under the State Plan.

B. Services for Children Under Age 21

Any services required for children under age 21, that are not covered elsewhere in this plan, will be provided.

Reimbursement for these services will be at an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services.

Services that are required for children under age 21 that are available only in a state other than Mississippi will be reimbursed at the lower of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation, or the Mississippi Medicaid maximum rate for that classification of facility. If the services are required at a type of facility for which the Mississippi Medicaid plan does not provide payment methodology, reimbursement will be made at the lesser of the provider's Medicaid rate, as defined by the Medicaid agency in the provider's state of operation or an amount not greater than ninety percent (90%) of the provider's usual and customary charges for the services. The Division of Medicaid will not reimburse a facility at a rate greater than the provider's customary charges to the general public for the services.

CHAPTER 2

STANDARDS FOR ALLOWABLE COSTS

2-1 Allowable and Non-Allowable Costs

The Division of Medicaid defines allowable and non-allowable costs to identify expenses which are reasonable and necessary to provide care to Nursing Facility, PRTF and ICF-MR residents. The standards listed below are established to provide guidance in determining whether certain selected cost items will be recognized as allowable costs. In the absence of specific instructions or guidelines in this plan, facilities will submit cost data for consideration for reimbursement. Allowable costs must be compiled on the basis of generally accepted accounting principles (GAAP). In cases where Division of Medicaid cost reporting rules conflict with GAAP, IRS or CMS PRM 15-1, Division of Medicaid rules take precedence for Medicaid provider cost reporting purposes. Allowable costs are based on CMS PRM 15-1 standards except as otherwise described in this plan. If the Division of Medicaid classifies a particular type of expense as non-allowable for the purpose of determining the rates, it does not mean that individual providers may not make expenditures of this type.

A. Allowable Costs

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

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

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

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

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

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

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

Costs of advertising for procurement of items or services related to patient care, and for sale or disposition of surplus or scrap material are treated as adjustments of the purchase or selling price.

Costs of advertising incurred in connection with obtaining bids for construction or renovation of the provider's facilities should be included in the capitalized cost of the asset.

Costs of informational listings of providers in a telephone directory, including the "yellow pages," or in a directory of similar facilities in a given area are allowable if the listings are consistent with practices that are common and accepted in the industry.

Costs of advertising for any purpose not specified above or not excluded in the non-allowable cost section of this plan may be allowable if they are related to patient care and are reasonable.

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

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

Nursing Facilities and ICF-MR Facilities	Annual Director's Fees
0 to 99 Beds	Total fees of $2,288 per meeting, maximum of 4 meetings per year
100 to 199 Beds	Total fees of $3,432 per meeting, maximum of 4 meetings per year
200 to 299 Beds	Total fees of $4,576 per meeting, maximum of 4 meetings per year
300 to 499 Beds	Total fees of $5,720 per meeting, maximum of 4 meetings per year
500 or More Beds	Total fees of $6,864 per meeting, maximum of 4 meetings per year

5. Compensation of Outside Consultants. This includes, but is not limited to, activities consultants, medical directors, registered nurses, pharmacists, social workers, dieticians, medical records consultants, psychologists, physical therapists, speech therapists, occupational therapists, dentists, and other outside services related to patient care.

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

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

vehicles, purchased for an amount equal to or greater than the new bed value determined for the year of the purchase in accordance with other portions of this plan, should be considered as either new beds, replaced beds, or a renovation. In facilities with distinct parts, purchases not solely related to the certified beds for the classification being considered will be allocated between the certified beds for the classification being considered and the other beds in the facility. The allocation will be based on the number of beds in the classification being considered to total facility beds at year end. The portion allocated to the classification being considered must be equal to or greater than the new bed value determined for the year of purchase in order to be considered as either new beds, replaced beds, or a renovation in accordance with the other portions of this plan. Portions allocated to the classification being considered which are below the new bed value determined for the year of purchase should be depreciated in accordance with this section. Assets purchased for use solely by the portion of the facility other than the classification being considered will not be considered as

new beds, replaced beds, renovated beds, or for depreciation expense.

8. Dues. Providers customarily maintain memberships in a variety of organizations and consider the costs incurred as a result of these memberships to be ordinary provider operating costs. Some of those organizations promote objectives in the provider's field of health care activity. Others have purposes or functions which bear little or no relationship to this activity. In order to determine for Medicaid purposes the allowable costs incurred as a result of membership in various organizations, memberships have been categorized into three basic groups: (A) professional, technical or business related; (B) civic; and (C) social, fraternal, and other. The Division of Medicaid will look to comparable providers, as well as to the justification by the individual provider, in determining the reasonableness of the number of organizations in which the provider maintains memberships and the claimed costs of such memberships.

A. Professional, Technical, or Business Related Organizations. Organizations are classified in this category if their functions and purposes can be reasonably related to the development and operation of patient care facilities and programs, or the rendering of patient care services. Memberships in these organizations are generally comprised of provider, provider personnel, or others who are involved or interested in patient care activities. Costs of memberships in such organizations are allowable for purposes of program reimbursement.

B. Civic Organizations. These organizations function for the purpose of implementing civic objectives. Reasonable costs of membership are an allowable cost. Examples of these types of dues are: American Legion, Chamber of Commerce, Rotary Club, Kiwanis Club, Lions Club, and Jaycees.

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

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

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

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

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

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

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

The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees, cost of qualifying the issues with the appropriate state or federal authorities, stamp taxes, etc.

Allowable organization costs should be amortized over a period of not less than sixty (60) months.

13. Owners' Salaries. A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed in a necessary function. The requirement that the function be necessary means that had the owner not rendered the services, the institution would have had to employ another person to perform them. The services must be pertinent to the operation and sound conduct of the facility.

Compensation paid to an employee who is an immediate relative of the owner of the facility is also reviewable

under the test of reasonableness. For this purpose, the following persons are considered "immediate relatives": husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother, and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild.

The maximum salary allowed for owners, including owner administrators shall be computed at 150% of the average salary paid to non-owner administrators for the previous calendar year for each classification of facilities. For example: The average salary of non-owner administrators for calendar year 1992 for each classification of facilities would be multiplied by one hundred and fifty percent (150%) to determine the maximum allowable owner administrator salary for calendar year 1993. Limits are published each year in the Medicaid Bulletin. The maximum compensation is considered to include forty or more work hours per week. The maximum will be decreased ratably for owners average time worked which is less than forty hours per week. Owners are allowed to receive compensation from more than one facility. Total hours

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

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

15. Salaries and Fringe Benefits. Allowable costs include payments for salaries and fringe benefits for those employees who provide services in the normal conduct of operations related to patient care. These employees include, but are not limited to, registered nurses, licensed practical nurses, nurses aides, other salaried direct care staff, director of nursing, dietary employees, housekeeping employees, maintenance staff, laundry employees, activities staff, pharmacy employees, social workers, medical records staff, non-owner administrator, non-owner assistant administrator, accountants and bookkeepers and other clerical and secretarial staff. Fringe benefits include:

A. Payroll taxes and insurance. This includes Federal Insurance Contributions Act (FICA), Social Security, unemployment compensation insurance and worker's compensation insurance.

B. Employee benefits. This includes employer paid health, life, accident and disability insurance for employees; uniform allowances; meals provided to

employees as part of their employment; contributions to employee pension plans; and deferred compensation. The allowable portion of deferred compensation is limited to the dollar amount that an employer contributes during a cost reporting period. The deferred compensation expense must represent a clearly enumerated liability of the employer to individual employees.

16. Start-Up Costs. In the period prior to admission of patients, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, they are subject to the reasonableness test and must be capitalized as deferred charges and amortized over a sixty (60) month period beginning with the month in which the first patient is admitted to the facility.

Start up costs include, for example, administrative and nursing salaries, utilities, taxes, insurance, mortgage and other interest, employee training costs, repairs and

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

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

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

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

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

19. Travel. Travel expenses incurred for facility business that is related to patient care are allowable costs. Travel must be documented as to the person traveling, dates of the trip, destination, purpose of the trip, expense description, and the cost. Travel incurred by employees not related to the owner for "in-town travel" (travel within the town of the facility) does not need to be itemized if the expenditure is less than $50.00.

20. Utilities. This includes electricity, natural gas, fuel oil, water, waste water, garbage collection, hazardous waste collection, telephone and communications and cable television charges.

B. Non-Allowable Costs

Certain expenses are considered non-allowable for Medicaid purposes because they are not normally incurred in providing patient care. These non-allowable costs include, but are not limited to, the following types of expenses.

1. Advertising Expense - Non-Allowable. Costs of fund-raising, including advertising, promotional, or publicity costs incurred for such a purpose, are not allowable.

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

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

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

2. Bad Debts. Bad debts are not an allowable cost for Medicaid reimbursement purposes.

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

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

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

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

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

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

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

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

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

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

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

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

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

2-2 Nurse Aide Training and Competency Testing

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

The costs of in-service training of certified nursing assistants are a nursing facility cost and are an allowable cost to be included on the nursing facility's cost report.

2-3 Related Party Transactions

A. Allowability of Costs

Costs applicable to services, facilities and supplies furnished to the provider by organizations or persons related to the provider by common ownership of 5% or more equity, control, interlocking directorates, or officers are allowable at the cost to the related organization. Such costs are allowable to the extent that they relate to patient care, are reasonable, ordinary, and necessary, and are not in excess of those costs incurred by a prudent cost-conscious buyer. These requirements apply to the sale, transfer, lease-back or rental of the property, plant or equipment or purchase of services of the related organization.

Allowability of costs is subject to the regulations prescribing the treatment of specific items as outlined in the Provider's Reimbursement Manual, SSA-HIM-15, Chapter 10 and Section 2150.3.

B. Determination of Common Ownership or Control

In determining whether a provider organization is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other.

C. Exception

An exception is provided to the general rule applicable to related organizations. The exception applies if the provider demonstrates by convincing evidence to the satisfaction of the fiscal agent and/or the Division of Medicaid:

1. That the supplying organization is a bona fide separate organization.

2. That a substantial part of the supplying organization's business activity of the type carried on with the provider is transacted with other organizations not related to the provider and the supplier by common ownership or control and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization.

3. That the services, facilities, or supplies are those which are commonly obtained by nursing facilities from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by nursing facilities.

4. That the charge to the provider is in line with the charge for such services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for such services, facilities, or supplies.

Where all of the conditions of this exception are met, the charges by the supplier to the provider for such services or supplies are allowable as costs.

D. Definitions

1. Reasonable - The consideration given for goods or services is the amount that would be acceptable to an independent buyer and seller in the same transaction.
2. Necessary - The purchase is required for normal, efficient, and continuing operation of the business.

3. Costs related to patient care - Include all necessary and proper costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. They include costs such as nursing costs, maintenance costs, administrative costs, costs of employee pension plans, normal standby costs, and others.

4. Costs not related to patient care - Costs not related to patient care are costs which are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Such costs are not allowable in computing reimbursable costs. They include, for example, cost of meals sold to visitors or employees, cost of drugs sold to other than patients, cost of operation of a gift shop, and similar items.

5. Related to provider - The provider to a significant extent is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities, or supplies. The existence of an

immediate family relationship will create an irrefutable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests are met. The following persons are considered immediate family for these purposes: (1) husband and wife; (2) natural parent, child, and sibling; (3) adopted child and adoptive parent; (4) step-parent, step-child, step-sister, and step-brother; (5) father-in-law, mother-in-law, sister-in-law, brother-in-law, son-in-law, and daughter-in-law; (7) grandparent and grandchild.

6. Common ownership - Common ownership exists when an individual or individuals possess ownership to the extent that significant control can be exercised.

2-4 Private Room Charge

The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room due to medical necessity prescribed and ordered by a physician. No extra charge will be made to the resident, his/her family, or the Medicaid program.

When a resident is in a private room, by resident or family choice, a resident may be charged the difference between the private room charge and the semi-private room charge if the provider informs the

resident at the time of his/her admission of the amount of the charge. Semi-private room accommodations are covered by the Medicaid reimbursement rate.

2-5 Reserved Bed Days Payments

The Division of Medicaid will reimburse a long-term care facility for bed days held for Title XIX recipients under the following conditions and limitations.

A. Hospital Leave

Facilities will be reimbursed a maximum of fifteen (15) days for each hospital stay for residents requiring acute hospital care. Residents must receive continuous acute care during acute hospital leave. Should a resident be moved from an acute care hospital bed to a bed in the hospital that is certified for a less than acute care service, the Medicaid program may not be billed for any period of time in which services other than acute care services are received by the resident. The period of leave will be determined by counting, as the first day of leave, the day the resident left the facility. A leave of absence for hospitalization is broken only if the resident returns to the facility for 24 hours or longer.

The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed may not be filled with another resident during the covered period of hospital leave. Facilities may not refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires nursing facility services.

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

B. Home/Therapeutic Leave

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

C. Bed Hold Days Payment

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

2-6 Feeding Assistant Training

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

CHAPTER 3

RATE COMPUTATION - NURSING FACILITIES

3-1 Rate Computation - Nursing Facilities - General Principles

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

3-2 Resident Assessments

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

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

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

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

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

B. Assessments Used to Compute a Facility's Average Case Mix Score.

All resident assessments completed per a calendar quarter will be used to compute the quarterly case mix average for a facility. These will include the last assessment from the previous calendar quarter. Therapeutic leave, hospital leave and bed hold days will be calculated

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

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

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

D. Roster Reports and Bed Hold Reports.

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

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

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

E. MDS Forms Which Can Not Be Classified. Should a facility submit an assessment that can not be classified into any of the Multi-State Medicare/Medicaid Payment Index (M^3PI) categories due to omissions of data or errors, the MDS form will be classified in the default case mix category of BC1. This category is the equivalent to the lowest case mix classification.

F. Failure to Submit MDS Forms. Nursing facilities that do not submit MDS forms will have the residents for which an assessment was not submitted classified in the default category of BC1, equivalent to the lowest case mix category until the next assessment is received. Delinquent assessments will result in the calculation of delinquent days at the default classification of BC1. Delinquent assessments are defined as those assessments not completed according to the

schedule required by the Division of Medicaid.

3-3 Resident Classification System

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

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

The seven (7) major categories in which a resident may be classified are as follows:

Extensive Services

Rehabilitation

Special Care

Clinically Complex

Impaired Cognition

Behavioral Problems

Reduced Physical Functioning

These seven (7) major categories split out into additional classifications based on specific criteria; namely Activities of Daily Living (ADL) Index, Depression, and Nursing Rehabilitation, each of which is described below.

ADL Index

The ADL Index is a composite score for assessing the ability of a resident to perform in four of the Activities of Daily Living - bed mobility, toilet use, transfer, and eating, as defined in the MDS manual. The ADL Index is **NOT** a total of the actual ADL scores on the MDS. A value is assigned to show how a resident is scored for ADL performance in the following manner:

For **Bed Mobility, Toilet Use, and Transfer**, residents who are coded as: **Independent** or needing **Supervision** receive a value of 1

Needing **Limited Assistance** receive a value of 3

Requiring **Extensive Assistance** or **Total Dependence**--

with 1 person physical assist receive a value of 4

with 2+ person physical assist receive a value of 5

For **Eating**, residents who are coded as:

Independent or need **Supervision** receive a value of 1

Needing **Limited Assistance** receive a value of 2

Requiring **Extensive Assistance/Total Dependence**:

(including feeding tubes and parenteral feeding) 3

The ADL Index may range from a low of four (4) to a high of eighteen (18). The following example illustrates how an ADL Index is computed. Assume a resident is independent in bed mobility, requires extensive assistance with one-person assist in toilet use, requires limited assistance with transferring and is independent in eating. This resident's ADL Index would be computed as follows:

-Bed mobility (independent)	1
-Toilet use (extensive assistance with 1-person assist)	4
-Transfer (limited assistance)	3
-Eating (independent)	1
ADL Index	**9**

The ADL Index is an extremely important component of all classifications, providing the final determination of group (Note: the exception is in the major category of Extensive Care where a resident must meet an ADL Index requirement before being classified into Extensive Care). An ADL Index is calculated for all assessments.

Depression Groups

The major category of Clinically Complex has first level splits which indicate whether or not a resident meets specific indicators of depression. In order to be classified in one of the depression groups, the following criteria must be present based on the MDS:

Persistent sad or anxious mood and **three or more** of the mood and behavior patterns specified in the version 5.12 of the Mississippi M^3PI.

Nursing Rehabilitation Groups

Three of the major categories have as their first level split a determination of whether or not a resident is receiving nursing rehabilitation activities. The major categories for which this split applies are Impaired Cognition, Behavior Problems, and Reduced Physical Functioning.

In order to be computed as receiving Nursing Rehabilitation, a resident must receive two (2) or more types of nursing rehabilitation at least six (6) days a week a minimum of fifteen (15) minutes a day. Nursing Rehabilitation includes the techniques/practices specified in the version 5.12 of the Mississippi M^3PI.

In a hierarchical classification system, assessments are sorted from those having the highest acuity/resource utilization to those with the least acuity/resource utilization. Once the criteria for placement in one of the seven major categories is met, the M^3PI calculation program looks at the assessment on the basis of the ADL Index and whether or not it meets the requirements for Depression or Nursing Rehabilitation. Once that has been determined, the final classification is made.

An additional classification is included to allow placement of assessments for whom calculation in the M^3PI is not possible due to errors. This classification (BC1) is given the same weight as the lowest classification.

The classification of residents will be performed by computer at the Division of Medicaid using the MDS assessments and the M^3PI calculation program. Submission requirements are addressed in section 3-2(A).

Each of the thirty-four (34) resident classifications as well as the default classification have been assigned case-mix weights. The Mississippi base weights for all M^{3}PI categories are listed in the following table for residents in regular units as well as residents with Alzheimer's or related dementia in licensed Alzheimer's Special Care Units. At such time that sufficient and relevant data is collected, the Mississippi case mix base weights may be re-calibrated.

MS MEDICARE/MEDICAID PAYMENT INDEX (M^{3}PI)
34 CATEGORIES

EXTENSIVE CARE CATEGORIES

M^{3}PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
SE3	Extensive Special Care 3	All ADLs > 6	2.839	2.839
SE2	Extensive Special Care 2	All ADLs > 6	2.316	2.316
SE1	Extensive Special Care 1	All ADLs > 6	1.943	1.943

REHABILITATION CATEGORIES

M^{3}PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
RAD	Rehabilitation All Levels	ADL 17 - 18	2.284	2.284
RAC	Rehabilitation All Levels	ADL 14 - 16	1.936	1.936
RAB	Rehabilitation All Levels	ADL 10 - 13	1.772	1.772
RAA	Rehabilitation All Levels	ADL 4 - 9	1.472	1.472

SPECIAL CARE CATEGORIES

M³PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
SSC	Special Care	ADL 17 - 18	1.877	1.877
SSB	Special Care	ADL 15 - 16	1.736	1.736
SSA	Special Care	ADL 7 - 14	1.709	1.709

CLINICALLY COMPLEX CATEGORIES

M³PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
CC2	CLN.COMP. W/DEPRESSION	ADL 17 - 18	1.425	1.824
CB2	CLN.COMP. W/DEPRESSION	ADL 12 - 16	1.247	1.596
CA2	CLN.COMP. W/DEPRESSION	ADL 4 - 11	1.043	1.335
CC1	CLIN. COMPLEX	ADL 17 - 18	1.311	1.678
CB1	CLIN. COMPLEX	ADL 12 - 16	1.154	1.477
CA1	CLIN. COMPLEX	ADL 4 - 11	0.934	1.196

COGNITIVELY IMPAIRED CATEGORIES

M³PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
IB2	COG.IMP.W/NURSING REHAB	ADL 6 - 10	1.061	1.825
IA2	COG.IMP.W/NURSING REHAB	ADL 4 - 5	0.777	1.336
IB1	COG.IMPAIRMENT	ADL 6 - 10	0.938	1.613
IA1	COG.IMPAIRMENT	ADL 4 - 5	0.703	1.209

BEHAVIOR PROBLEMS CATEGORIES

M³PI GROUP	DESCRIPTION	ADL	SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
BB2	BVR PRBMS W/NURSING REHAB	ADL	6 - 10	1.021	1.756
BA2	BVR PRBMS W/NURSING REHAB	ADL	4 - 5	0.750	1.290
BB1	BEHAVIOR PROBLEMS	ADL	6 - 10	0.866	1.490
BA1	BEHAVIOR PROBLEMS	ADL	4 - 5	0.612	1.053

PHYSICAL FUNCTIONING CATEGORIES

M³PI GROUP	DESCRIPTION	ADL	SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
PE2	PHYS.FUNC.W/NURSING REHAB	ADL	16 - 18	1.188	1.521
PD2	PHYS.FUNC.W/NURSING REHAB	ADL	11 - 15	1.095	1.402
PC2	PHYS.FUNC.W/NURSING REHAB	ADL	9 - 10	0.937	1.199
PB2	PHYS.FUNC.W/NURSING REHAB	ADL	6 - 8	0.824	1.055
PA2	PHYS.FUNC.W/NURSING REHAB	ADL	4 - 5	0.637	0.815
PE1	PHYS.FUNC.	ADL	16 - 18	1.077	1.379
PD1	PHYS.FUNC.	ADL	11 - 15	0.990	1.267
PC1	PHYS.FUNC.	ADL	9 - 10	0.865	1.107
PB1	PHYS.FUNC.	ADL	6 - 8	0.749	0.959
PA1	PHYS.FUNC.	ADL	4 - 5	0.575	0.736

DEFAULT CATEGORY

M³PI GROUP	DESCRIPTION	ADL SCORE	MISSISSIPPI BASE WEIGHT REGULAR UNIT	MISSISSIPPI BASE WEIGHT ALZHEIMER'S UNIT
BC1	DEFAULT CATEGORY	NOT APPLICABLE	0.575	0.575

RESIDENT ASSESSMENTS THAT CONTAIN ERRORS IN FIELDS WHICH PROHIBIT CLASSIFICATION WILL AUTOMATICALLY BE PLACED INTO THIS CATEGORY BY DEFAULT.

3-4 Computation of Per Diem Rate for Nursing Facilities

A per diem base rate will be established annually, unless this plan requires a rate being calculated at another time, for the period July 1 through June 30 until June 30, 2000. The rates established for the period July 1, 1999 through June 30, 2000 will be trended forward to establish rates for the period July 1, 2000 through December 31, 2000. For example, the trend factor established for the rate year July 1, 1999 through June 30, 2000 will be adjusted for each cost report period used to establish the rates for that period in order for the trend factor to be from the mid-point of the cost report period to the mid-point of the rate year. Facilities which filed a cost report for the period January 1, 1998 through December 31, 1998 originally had the trend factor that was established in accordance with this plan multiplied by 1.5 in order to adjust from the midpoint of the cost report period (July 1, 1998) to the midpoint of the rate year (January 1, 2000). In order to set the rates for the period July 1, 2000 through December 31, 2000, that same trend factor will be multiplied by 2.25 in order to adjust from the midpoint of the cost report period (July 1, 1998) to the midpoint of the rate period (October 1, 2000). Beginning January 1, 2001, the per diem base rate year will be January 1 through December 31, unless this plan requires a rate being calculated at another time. A case mix adjustment will be made quarterly based on the MDS forms submitted by each facility in accordance with other provisions of this plan. Cost

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

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

A. Direct Care Base Rate and Care Related Rate Determination

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

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

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

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

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

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

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

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

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

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

determined by multiplying the median cost by ninety percent (90%).

The floor will be computed only for the payment periods July 1, 1993 through June 30, 1994 (FY 1994) and July 1, 1994 through June 30, 1995 (FY 1995). Facilities which receive the floor for direct care and care related costs must increase their allowable costs in these areas in order to avoid the repayment of the amount not spent on direct care and care related costs. The comparison of the floor and actual costs will be after the costs are case mix adjusted to an average of 1.00. In addition, costs incurred (not trended) will be compared to the floor that was computed using trended costs for the rate period. Since the cost report periods and the rate periods are not the same, an adjustment will be made to the repayment amount for facilities which receive the floor payment for only a portion of their cost report period. In no case will the recoupment be greater than the amount paid for the difference in trended

direct care and care related costs and the floor. A facility that qualifies for the floor for FY 1994 will not necessarily qualify for the floor for FY 1995. Likewise, a facility that does not qualify for the floor in FY 1994 may receive the floor for FY 1995 if their direct care and care related costs are lower than 90% of the median.

For example: XYZ Nursing Facility has trended direct care and care related costs of $15.00 per day, as determined in 5, above, for the period January 1, 1992 through December 31, 1992. Assume that the median for direct care and care related costs is $22.00 when the base rates are determined for the period July 1, 1993 through June 30, 1994 (FY 1994). Therefore, 90% of the median is $19.80. Accordingly, the direct care and care related base rate of XYZ Nursing Facility will be increased by $4.80 to the floor for the FY 1994 rate period. Since the facility did not receive the incentive of the 90% floor six (6) months of the next reporting period, XYZ Nursing Facility must increase their

allowable direct care and care related costs by one-half (1/2) of the amount of the difference between the direct care and care related costs from the cost report used to compute the rate and the floor. In this example, the cost report filed by XYZ Nursing Facility for the period January 1, 1993 through December 31, 1993 must have allowable direct care and care related costs of at least $17.40 per day, case mix adjusted, in order to avoid the recoupment of a portion of the floor payment. If the allowable direct care and care related costs are $17.00 on the 1993 cost report, the direct care and care related base rate of XYZ Nursing Facility for FY 1994 will be reduced to $19.40, a $.40 reduction. This will be repaid to the Medicaid program by a retroactive rate adjustment for the period in which the floor was paid. The Medicaid fiscal agent would recoup the amount paid for each claim and repay the claims at the adjusted rate.

Starting July 1, 1993 and only during FY 1994 and FY 1995, a nursing facility may file one

abbreviated cost report per state fiscal year consisting of Forms 2, 3, 5 and 6 for any calendar quarter in order to prove they have equaled or exceeded the floor. The abbreviated cost report will only be used to determine if their actual costs (without a trend factor) were greater than or equal to the floor computed during the annual rate setting process. The standard per diem rate of the facility will not be changed as a result of the abbreviated cost report. If a nursing facility has incurred direct care and care related costs that equal or exceed the floor, the nursing facility will be eligible to receive the Direct Care Access and Quality Incentives beginning the second (2nd) calendar quarter following the abbreviated cost report period. The abbreviated cost report may not be substituted for any part of the annual cost report required for each nursing facility. If, when the annual cost report is filed, a nursing facility which filed an abbreviated cost report in order to receive the Direct Care Access and Quality Incentives is found to be below the floor for the

cost report period, the facility must repay the Direct Care Access and Quality Incentives as well as the portion of costs below the floor as described above and the facility will be ineligible for the Direct Care Access and Quality Incentives for the remainder of the rate year. Facilities which file an abbreviated cost report must do so within thirty (30) days following the end of the calendar quarter contained in the abbreviated cost report.

7. Determine the standard rate for each facility for direct care and care related costs. If the facility's case mix adjusted cost is above the ceiling, its standard rate is the ceiling. If the facility falls below the ceiling and above the floor, then its standard rate is its case mix adjusted cost. If a facility falls below the floor, its standard rate is the floor.

8. Allocate each facility's Standard Rate between direct care costs and care related costs. This is done by using the percentage of case mix adjusted direct care costs and care related costs to the total of these costs used in 4, above, for each facility. This will result in the

Standard Case Mix Adjusted Direct Care Base Rate and the Care Related Per Diem Rate.

9. The Standard Case Mix Adjusted Direct Care Base Rate of each facility will be multiplied by the facility's average case mix score as described in Section C, below,
on a quarterly basis. The facility's average case mix score will be computed using the access and quality weights as described in Section B, below.

B. Direct Care Access and Quality Incentives

In computing the average case mix for each nursing facility to be used in adjusting the direct care base rate, direct care access and quality incentives will be used. These incentives are only available to facilities whose case mix adjusted direct care and care related costs are greater than or equal to 90% of the median for the cost report period being used to compute the base rate. These incentives will increase the Mississippi Base Weights used to compute the average case mix score for the appropriate calendar quarter. The direct care

access and quality incentives will increase the base weight by two percent (2%) for the following case mix categories:

DESCRIPTION	M^3PI GROUP	DIRECT CARE ACCESS & QUALITY INCENTIVE WEIGHTS REGULAR UNIT	ALZHEIMER'S UNIT
Extensive	SE3	2.896	2.896
Extensive 2	SE2	2.362	2.362
Extensive 1	SE1	1.982	1.982
Rehab 17-18	RAD	2.330	2.330
Rehab 14-16	RAC	1.975	1.975
Rehab 10-13	RAB	1.807	1.807
Rehab 4-9	RAA	1.501	1.501
Special 17-18	SSC	1.915	1.915
Special 15-16	SSB	1.771	1.771
Special 7-14	SSA	1.743	1.743
Complex 17-18D	CC2	1.454	1.860
Complex 17-18	CC1	1.337	1.712
Complex 12-16D	CB2	1.272	1.628
Complex 12-16	CB1	1.177	1.507
Complex 4-11D	CA2	1.064	1.362
Complex 4-11	CA1	0.953	1.219
Impaired 6-10N	IB2	1.082	1.861
Impaired 6-10	IB1	0.957	1.646
Behavior 6-10N	BB2	1.041	1.791
Behavior 6-10	BB1	0.883	1.519
Physical 16-18N	PE2	1.212	1.551
Physical 11-15N	PD2	1.117	1.430
Physical 9-10N	PC2	0.956	1.223
Physical 6-8N	PB2	0.841	1.076

C. Case Mix Adjusted Per Diem Rate

A per diem rate will be calculated for each nursing facility on a quarterly basis. Each nursing facility's standard direct care rate will be multiplied by their average case mix for the period two calendar quarters prior to the start date of the rate being calculated. For example, the July 1, 1993 rate

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

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

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

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

3. Determine the ceiling for therapy costs as follows:

A. Prepare an array for the classification, including the facility names, the associated trended therapy costs, and the annualized total patient days.

B. Arrange the data from lowest to highest cost.

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

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

E. Determine the median cost by matching the median patient day to the associated costs. This may require interpolation.

F. Multiply the cost at the median patient day by 105% to determine the ceiling.

4. Determine the therapy per diem rate for each facility. If the facility's therapy cost is above the ceiling, its therapy rate is the ceiling. If the facility's cost falls below the ceiling, then its therapy rate is its trended cost.

E. Administrative and Operating Rate

Administrative and operating costs include salaries and fringe benefits for the administrator, assistant administrator, dietary, housekeeping, laundry, maintenance, medical records, owners and other administrative staff. These costs also include contract costs for dietary, housekeeping, laundry and maintenance, dietary and medical records consultants, accounting

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

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

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

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

E. Determine the median costs by matching the median patient days to the associated costs. This may require interpolation.

F. The cost at the median patient day is multiplied by 109% to determine the ceiling for each classification.

4. Determine the per diem rate for each facility for administrative and operating costs. If the facility's administrative and operating cost is above the ceiling, its administrative and operating rate is the ceiling. If the facility's cost falls below the ceiling, then its administrative and operating rate is its trended cost plus seventy-five percent (75%) of the difference between the greater of the trended cost or the median and the ceiling. For PNFSD's with 60 Medicaid certified beds or less, the ceiling calculated for the small nursing facility class will be used. For PNFSD's with greater than 60 Medicaid certified beds, the large nursing facility class will be used.

F. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 1992 is assumed to have a per bed value of $25,908. The value of new construction will be indexed each year using the RS Means Construction Cost Index. The new bed value will be indexed each year to January 1 of the payment year. The cost index

will be estimated using a five year moving average of the most recent cost indices for Jackson, MS. For example, in computing the rates for the year January 1, 2001 through December 31, 2001, the new bed value will be indexed to January 1, 2001 using the estimated index. An adjustment to the new bed value of 37.20% will be made for licensed Alzheimer's units based on the additional construction costs required to be licensed as an Alzheimer's unit. Likewise, an adjustment to the new bed value of 328.178% will be made for PNFSD's.

2. The fair rental system establishes a facility's value based on its age. The older the facility, the less its value. Additions, replacements, and renovations will be recognized by lowering the age of the facility and, thus, increasing the facility's value. Facilities, one year or older, will be valued at the new construction bed value less depreciation of 1% per year according to the age of the facility. Facilities will not be depreciated to an amount less than seventy percent (70%) of the new construction bed value. For sales of assets closed on or after July 1, 1993, there will be no recapture of depreciation.

   a. Addition of Beds. The addition of beds will require a computation of the weighted average age of the facility based on the construction dates of

the original facility and the additions. For example, a 60 bed facility that was constructed in 1977 and constructed 60 additional beds in 1982 would have its weighted average age (compared to 1992) calculated as follows:

Construction Year	Age	Beds	Age X Beds
1977	15	60	900
1982	10	60	600
Total		120	1,500

Weighted Average Age = 1,500 / 120 = 12.50 years

If the new bed value of a facility in 1992 is $25,908 and it is depreciated at 1% per year for an age of 12.50 years, then the facility's fair rental value would be $22,670 per bed ($25,908 X .875), or a total of $2,720,400 for fiscal year 1992.

The increase or decrease in the number of certified beds that does not result in a change of classification will be reflected in the facility rate for the next quarter after the Division of Medicaid is notified of the change in the number of

certified beds if the Division of Medicaid receives the notification from the certifying agency on or before the first day of the month preceding the effective date of the quarterly rate change. For example, a facility increases its number of Medicaid beds from 100 to 110 effective August 1, 1993. The rate of the facility would reflect 100 beds for the period July 1, 1993 through September 30, 1993. The rate would reflect 110 beds for the period October 1, 1993 through December 31, 1993. If the change in the number of beds had been effective September 1, 1993 and the Division of Medicaid did not receive notification until September 15, 1993, the increase would be reflected in the rate effective January 1, 1994.

The addition of beds is often a result of the conversion of non-Medicaid-certified nursing facility beds other than hospital beds, ex. personal care beds. The added beds will be aged using the aging calculation made at start-up of the fair rental system for the converting beds. The cost of renovations or major improvements after start-up and before conversion will be considered in determining the age of the beds upon conversion if the facility provides documentation as described elsewhere in the plan at the time of conversion.

When Medicaid-certified beds are added to the facility as a result of the conversion of hospital beds, the converted beds will be assigned the average age of the Medicaid-certified beds calculated for start-up of the fair rental system. The cost of renovations or major improvements after start-up and before conversion will be considered in determining the age of the beds upon conversion if the facility provides documentation as described elsewhere in the plan at the time of conversion. Direct hospital costs will not be considered.

b. Replacement of Beds. The replacement of existing beds will also result in an adjustment to the age of the facility. A weighted average age will be calculated according to the year of initial construction and the year of bed replacement. This differs from the addition of beds in that a certain number of beds have replaced those that were

initially constructed. If a facility has a series of additions or replacements, it is assumed that the oldest beds are the ones being replaced. For example, a 120 bed facility constructed in 1978 that replaced 60 beds in 1988 would have their weighted average age computed as follows in 1993:

Construction Year	Age	Beds	Age X Beds
1978 (initial beds remaining)	15	60	900
1988 (beds replaced)	5	60	300
Total		120	1,200

Weighted Average Age = 1,200 / 120 = 10.00 years

The replacement of 60 beds in 1988 reduced the age of the facility by 5 years, from 15 years to 10 years. Assuming a new bed value of $26,300, depreciated at 1% per year for an age of 10.00 years, the facility's fair rental value would be $23,670 per bed ($26,300 X 90%), or a total of $2,840,400 for fiscal year 1993.

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c. Renovations or Major Improvements. Renovations or major improvements are difficult to factor into the age of the facility because ordinarily they cannot be associated with particular beds. The cost of

renovation or improving the facility will be calculated as a bed replacement, described above. To qualify as a bed replacement, the cost of the renovation/improvement must be equal to or greater than the cost of constructing one nursing facility bed in the year in which the renovation takes place. For example, a renovation/improvement in 1993 must cost at least $26,300 for it to qualify as a bed replacement.

Renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts, or other means. Costs must be capitalized in order to be considered a renovation or major improvement. In facilities with distinct parts, purchases not solely related to the certified beds for the classification being considered will be allocated between the certified beds for the classification being considered and the other beds in the facility. The allocation will be based on the number of beds in the classification being considered to total facility

beds at year end. The portion allocated to the classification being considered must be equal to or greater than the new bed value determined for the year of purchase in order to be considered for a renovation/improvement. Assets purchased for use solely by the portion of the facility other than the classification being considered will not be considered for renovations/improvements for the Medicaid certified beds.

In establishing the age of a facility renovations/improvements are converted into bed replacements by dividing their total cost by the new construction cost for a nursing facility bed in the year of renovation/improvement. For example, if a renovation costing $200,000 takes place in 1993, its bed replacement equivalent is $200,000 / $26,300 = 7.60 beds. The bed replacement equivalents will be rounded to the next highest integer (7.60 = 8).

For example, a 120 bed facility constructed in 1978 might have undertaken two renovations: $200,000 in

1983 and $200,000 in 1993. The bed replacement equivalent of these renovations would be 9 beds and 8 beds respectively. The weighted average for this facility would be calculated as follows:

Construction Year	Age 1/01/95	Beds	Age X Beds
1978 (initial beds remaining)	17	103	1,751
1983 (bed replacement equivalent)	12	9	108
1993 (bed replacement equivalent)	2	8	16
Total		120	1,875

Weighted Average Age = 1,875 / 120 = 15.63 years

The renovations reduced the age of the facility by 1.37 years, from 17 to 15.63. Assuming a 1995 new bed value of $27,604, depreciated at 1% per year for an age of 15.63 years, the facility's fair rental value would be $23,289 per bed ($27,604 X .8437), for a total of $2,794,680 for rate period fiscal year 1995.

Beds constructed after the cost report year will be considered to have a zero (0) age for rate setting purposes. All beds will be aged by one (1) year at each December 31.

d. Start Up of Fair Rental System. To start up the fair rental system, each facility's bed values must be determined based on the age of the facility. The determination will include setting a value for the original construction of beds with adjustments for any additions, bed replacements, and renovations/improvements. For determination of bed values for use in determining the FY 1994 rate, the procedures described above for determining the values of original beds, additions, and replacements will be used.

However, for start-up purposes only, the cost of renovation or improving the facility will be calculated as having brought a portion of old beds up to new bed value in the year of renovation, not as bed replacement. To qualify as a renovation/ improvement which affects the age of the facility, the cost of the renovation/improvement must be equal to or greater than $25,908. Renovation/ improvement costs must be documented through cost reports, depreciation schedules, construction

receipts, or other means. Costs must have been capitalized in order to be considered a renovation or major improvement. It will also be assumed that the oldest beds were renovated. Renovations/ improvements exclude vehicles. In facilities with distinct parts, purchases not solely related to the certified beds for the classification being considered will be allocated between the certified beds for the classification being considered and the other beds in the facility. The allocation will be based on the number of beds in the classification being considered to total facility beds at year end, except for nursing facility beds converted from an existing hospital. In facilities where nursing facility beds were converted from hospitals, the beds will be aged at the actual construction date of the hospital beds up to thirty years. Also in facilities where nursing facility beds were converted from hospitals, renovations/

improvements will be allocated for each of the years considered in start-up as if the original number of converted beds were nursing facility beds in the year of construction. Non-Medicaid-certified beds other than hospital beds, ex. personal care beds, that exist in a facility will be aged at start-up using the same criteria as Medicaid-certified beds. A weighted average age calculation will be made for these beds separate from the Medicaid-certified bed age calculation. For all facilities, the portion allocated to the classification being considered must be equal to or greater than the new bed value determined for the year of purchase in order to be considered as a renovation/improvement in accordance with other provisions of this plan. Assets purchased for use solely by the portion of the facility other than the classification being considered will not be considered.

In establishing the age of a facility for start-up, renovations/improvements are converted into new bed equivalents by dividing the renovation cost by the difference between the new bed value in the year of

the renovations and the residual value of beds immediately prior to the renovation. The residual value is established by depreciating the new bed value in the year of the renovation by one percent (1%) per year for each year between the date of the renovation and the date that beds were originally constructed.

The following is an example of these calculations for a facility with 120 beds originally constructed in 1973 that underwent a $200,000 renovation in 1983.

Year of renovation	1983
Year of Original Construction	1973
Age of Beds Immediately Prior to Renovation	10 Years
1983 New Bed Value (from Table below)	$22,294
1983 Residual Value of Original Beds: New Bed Value Depreciated at 1% Per Year for 10 Years ($22,294 X .90)	$20,065
Difference Between New Bed and Residual Value	$2,229

Cost of Renovation	$200,000
New Bed Equivalent ($200,000 / $2,229)	89.7
New Bed Equivalent - Rounded	90

The weighted average age for this facility would be calculated as follows:

Construction Year	Age 1/01/94	Beds	Age X Beds
1973 (initial beds remaining)	21	30	630
1983 (new bed equivalent)	11	90	990
Total		120	1,620

Weighted Average Age = 1,620 / 120 = 13.50 years

The renovations reduced the age of the facility by 7.5 years, from 21 to 13.50. Assuming a 1994 new bed value of $26,750, depreciated at 1% per year for an age of 13.50 years, the facility's fair rental value would be $23,139 per bed ($26,750 X (100%-13.5%)), for a total facility value of $2,776,680 ($23,139 X 120) for fiscal year 1994.

The new bed value will be published each year in the Medicaid Bulletin. Following is the table of the RS Means Construction Cost Index for Jackson, MS as applied to the Mississippi fair rental system.

NEW CONSTRUCTION VALUE PER BED FOR NURSING FACILITIES USING THE RS MEANS CONSTRUCTION COST INDEX FOR JACKSON, MS

FOR CALENDAR YEAR	RS MEANS INDEX SCORE	NEW CONSTRUCTION VALUE PER BED
1963	36.00	$5,225
1964	36.70	$5,327
1965	37.40	$5,428
1966	38.97	$5,656
1967	40.53	$5,883
1968	42.10	$6,111
1969	44.70	$6,488
1970	48.50	$7,039
1971	53.30	$7,736
1972	57.90	$8,404
1973	62.30	$9,042
1974	70.30	$10,204
1975	86.00	$12,482
1976	89.70	$13,019
1977	96.50	$14,006
1978	104.60	$15,182
1979	112.60	$16,343
1980	123.90	$17,983
1981	134.80	$19,565
1982	142.80	$20,726
1983	153.60	$22,294
1984	154.10	$22,367
1985	156.40	$22,700
1986	159.60	$23,165
1987	162.80	$23,629
1988	166.40	$24,152
1989	169.20	$24,558
1990	172.60	$25,052
1991	175.50	$25,473
1992	178.50	$25,908
1993	181.20	$26,300
1994	184.30E	$26,750

3. The per bed value will be multiplied by the number of beds in the facility to estimate the facility's total current value.

4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10-year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of seven and one-half percent (7.5%) per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of two percent (2%) will be added to the index value. The rental factor is multiplied by the facility's total value, as determined in 3. above, to determine the annual fair rental value.

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

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

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

MS PROPERTY REIMBURSEMENT - FAIR RENTAL SYSTEM EXAMPLE

Per Bed Value of New Nursing Facility	$26,750 (including building, land and equipment) on January 1, 1994
Per Bed Value of Specific Facility (Based on Annual Depreciation for age of Facility)	Depreciation of new bed value at 1% per year based on year of construction or bed replacement, not to exceed 30% of exceed 30% of the new bed value (30 years). Example: Facility constructed in 1984 Depreciated value: 26,750 x .90=24,075
Facility's Total Current Value	Per Bed Value x Number of Beds Example: 120 Bed Facility Facility value=24,075 x 120=2,889,000
Rental Factor	Federal Reserve Treas.Bond Composite + Risk Premium Example: Rental Factor = 7.5% + 2.0%=9.5%
Annual Fair Rental Value	Facility Value x Rental Factor Example: Rental Value = $2,889,000 x 9.5% = $274,455
Fair Rental Per Diem	Rental Value / Annualized Total Patient Days Example: Rental payment = $274,455/ 41,610 = $6.60

Property Insurance and Property Taxes	Pass Through Based on Annualized Reported Costs / Annualized Total Patient Days Example: Property Taxes $0.65 Prop. Insurance 0.60 Total $1.25
Per Diem Property Payment	Rental Payment + Taxes & Insurance Example: Per Diem Property Payment = $6.60 + $1.25 = $7.75
Hold Harmless Per Diem (Facility Below the Ceiling)	Example: Reported Per Diem Property Cost (Interest, Amortization, and Depreciation) = $7.11 Less: Fair rental per diem 6.60 Hold Harmless Payment $ .51
Return on Non-Property Equity Per Diem	*Average Non-Property Equity x Rental Factor / Annualized Total Patient Days Example: Avg. Non-Property Equity= $156,500 x 9.5% (rental factor)/ 41,610 = $.36 * subject to limitation of two (2) months of reported allowable costs

G. Return on Equity Payment

The facility's average net working capital for the reporting period maintained for necessary and proper operation of patient care activities will be multiplied by the rental factor used in the property payment to determine the return on equity payment. The return on equity payment will be divided

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

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

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

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

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

d. Notes and loans receivable from owners or related organizations;

e. Goodwill;

f. Unpaid capital surplus;

g. Treasury Stock;

h. Unrealized capital appreciation surplus;

i. Cash surrender value of life insurance policies;

j. Prepaid premiums on life insurance policies;

k. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;

l. Inter-company accounts;

m. Funded depreciation;

n. Cash investments that are long term (more than six months);

o. Deferred tax liability attributed to non-allowable tax expense;

p. Any other assets not directly related to or necessary for the provision of patient care;

q. Net capitalized loan/financing costs;

r. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;

S. Workmen's Compensation self insurance fund.

H. Total Base Rate

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

I. Calculation of the Rate for One Provider

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

3-5 Occupancy Allowance

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

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

X 80%) to equal a minimum of eighty percent (80%) occupancy. Reserved bed days will be counted as an occupied bed for this computation. Facilities having an occupancy rate of less than eighty percent (80%) should complete Form 14 when submitting their cost report.

3-6 State Owned NF's

NF's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs, subject to the Medicare upper limit. A state owned NF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned NF's file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period, subject to the Medicare upper limit.

3-7 Adjustments to the Rate for Changes in Law or Regulation

Adjustments may be made to the rate as necessary to comply with changes in state or federal law or regulation.

3-8 Upper Payment Limit

NF's may be reimbursed in accordance with the applicable regulations regarding the Medicaid upper payment limit. For each facility, the amount that Medicare would have paid for the previous year will be calculated and compared to what payments were actually made by Medicaid during that same time period. The calculation will be made as follows: MDS data is run for each facility to group total patient days into one of the forty-four RUGs. The total population is used, case mix adjusted, and the therapy portion is removed. An estimated amount that Medicare would have paid on average by facility is calculated by multiplying each adjusted RUG rate by the number of days for that RUG. The sum is then divided by the total days for the estimated average per diem by facility that Medicare would have paid. From this amount, the Medicaid average per diem for the time period is subtracted to determine the UPL balance as a per diem. The per diem is then multiplied by the Medicaid days for the period to calculate the available UPL balance amount for each facility. This calculation may then be used to make payment for the current year to nursing facilities eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. Up to 100 percent of the difference between Medicaid payments and what Medicare would have paid may be paid to State government-owned or operated facilities, non-state government-owned or operated facilities, and privately owned and operated facilities, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

CHAPTER 4
RATE COMPUTATION - ICF-MR'S

4-1 Rate Computation - ICF-MR's - General Principles

It is the intent of the Division of Medicaid to reimburse Intermediate Care Facilities for the Mentally Retarded a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care costs, therapy costs, care related costs, and administrative and operating costs less than 110% of the median, property costs that do not require a payment of the hold harmless provision and an occupancy rate of 80% or more.

4-2 Computation of Rate for Intermediate Care Facilities for the Mentally Retarded

A per diem rate will be established annually, unless this plan requires a rate being calculated at another time, for the period July 1 through June 30 until June 30, 2000. The rates established for the period July 1, 1999 through June 30, 2000 will be trended forward to establish rates for the period July 1, 2000 through December 31, 2000 as described in the Computation of Per Diem Rate for Nursing Facilities section (Section 3-4) of this plan. Beginning January 1, 2001, the per diem rate year will be January 1 through December 31, unless this plan requires a rate being calculated at another time. Cost reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the next calendar rate year, unless this plan requires a short period cost report to be used to compute the facility rate. For example, the rates effective January 1, 2001 will be determined from cost reports filed for the cost report year ended in 1999 unless a

short period cost report and rate calculation is required by other provisions of this plan. Costs used in the rate calculations may be adjusted by the amount of anticipated increase in costs or decrease in costs due to federal or state laws or regulations. A description of the calculation of the rate is as follows:

A. Direct Care, Therapies, Care Related, and Administrative and Operating Rate Determination

1. Determine the per diem cost for direct care costs, therapies, care related costs, and administrative and operating costs for each facility during the cost report period. This is done by adding the total allowable costs for these cost centers and dividing the result by the total patient days.

2. Trend each facility's per diem cost as determined in 1, above, to the middle of the rate year using the ICF-MR and PRTF Trend Factor. This is done by multiplying the ICF-MR and PRTF Trend Factor in order to trend costs forward from the mid-point of

of the cost report period to the mid-point of the payment period.

3. Array the trended costs from the lowest cost to the highest cost.

4. Determine the ceiling for direct care costs, therapies, care related costs, and administrative and operating costs. The ceiling is based on 110% of the cost associated with the median patient day. The median is determined by accumulating the annualized total patient days for each facility in the array described in 3, above. The trended cost that is associated with the mid-point of the total patient days is determined by multiplying the total patient days by fifty percent (50%) and interpolating to determine the median cost. The cost at the median is multiplied by 110% to determine the ceiling.

5. Determine the per diem rate for each facility for direct care costs, therapies, care related costs and administrative and operating costs. If the facility's cost is above the ceiling, its rate is the ceiling. If the facility falls below the

ceiling, then its rate is its trended cost plus fifty percent (50%) of the difference between the trended cost or the median, whichever is greater, and the ceiling.

B. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 1992 is assumed to have a per bed value of $31,090, which is the per bed value of a nursing facility multiplied by one hundred twenty percent (120%). The value of new construction of a nursing facility bed will be indexed each year using the RS Means Construction Cost Index. The indexed value of new construction of a nursing facility bed will be multiplied by one hundred twenty percent (120%). The new bed value will be indexed each year to January 1 of the payment year. The cost index for the payment year will be estimated by using a five-year moving average of the most recent cost indices for Jackson, MS.

2. Existing facilities, one year or older, will be valued at the new construction bed value less depreciation of 1% per year according to the age of the facility. Facilities will not be depreciated to an amount less than 30% of the new construction bed value. Facilities which were constructed in one year and then added additional beds in later years will be valued based upon the original construction date for the original beds and the added beds will be valued based upon their construction date.
3. The per bed value will be multiplied by the number of beds in the facility to estimate the facility's total current value.
4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10-year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of seven and one-half percent (7.5%) per annum and an imposed upper limit of ten percent (10%) per annum plus a risk premium. A risk premium in the amount of two percent (2%) will be added to the index value. The rental factor is multiplied by the facility's total value, as determined in 3, above, to determine the annual fair rental value.

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

C. Return on Equity Payment

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

which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

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

a. Property, plant, and equipment, excluding vehicles;
b. Debt related to property, plant, and equipment, excluding vehicles;
c. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
d. Notes and loans receivable from owners or related organizations;
e. Goodwill;
f. Unpaid capital surplus;
g. Treasury Stock;

h. Unrealized capital appreciation surplus;

i. Cash surrender value of life insurance policies;

j. Prepaid premiums on life insurance policies;

k. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;

l. Inter-company accounts;

m. Funded depreciation;

n. Cash investments that are long term (six months or longer);

o. Deferred tax liability attributed to non-allowable tax expense;

p. Any other assets not directly related to or necessary for the provision of patient care;

q. Net capitalized loan/financing costs;

r. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;

s. Workmen's Compensation self insurance fund.

D. Total Rate

The annual rate is the sum of the per diem rate for direct care costs, therapies, care related costs and

administrative and operating costs, the per diem property payment, the per diem hold harmless payment, and the per diem return on equity payment.

E. State Owned ICF-MR's

ICF-MR's that are owned by the State of Mississippi will be included in the rate setting process described above in order to calculate a prospective rate for each facility. However, state owned facilities will be paid based on 100% of allowable costs. A state owned ICF-MR may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned ICF-MR's file their cost report, the per diem rate for each cost report period will be adjusted to the actual allowable cost for that period.

CHAPTER 5
RATE COMPUTATION - PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

5-1 Rate Computation - Psychiatric Residential Treatment Facilities (PRTF's) - General Principles

It is the intent of the Division of Medicaid to reimburse Psychiatric Residential Treatment Facilities (PRTF's) a rate that is adequate for an efficiently and economically operated facility. An efficiently and economically operated facility is defined as one with direct care costs, therapy costs, care related costs, and administrative and operating costs less than 110% of the median, property costs that do not require a payment of the hold harmless provision and an occupancy rate of 80% or more.

5-2 Rate Computation for PRTF's

A per diem rate will be established annually, unless this plan requires a rate being calculated at another time, for the period January 1 through December 31, unless this plan requires a rate being calculated at another time. Cost reports used to calculate the rate will be the cost report filed for the period ending in the second calendar year prior to the beginning of the calendar rate year, unless this plan requires a short period cost report to be used to compute

the facility rate. For example, the rates effective January 1, 2001 will be determined from cost reports filed for the cost report year ended in 1999 unless a short period cost report and rate calculation is required by other provisions of this plan. Costs used in the rate calculations may be adjusted by the amount of anticipated increase in costs or decrease in costs due to federal or state laws or regulations.

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

A. Direct Care, Therapies, Care Related, and Administrative and Operating Rate Determination

1. Determine the per diem cost for direct care costs, therapies, care related costs, and administrative and operating costs for each facility during the cost report period. This is done by adding the total allowable costs for these cost centers and dividing the result by the total patient days.
2. Trend each facility's per diem cost as determined in 1, above, to the middle of the rate year using the ICF-MR and PRTF Trend Factor. This is done by multiplying the ICF-MR and PRTF Trend Factor in order to trend costs forward from the mid-point of the cost report period to the mid-point of the payment period.

3. Array the trended costs from the lowest cost to the highest cost.

4. Determine the ceiling for direct care costs, therapies, care related costs, and administrative and operating costs. The ceiling is based on 110% of the cost associated with the median patient day. The median is determined by accumulating the annualized total patient days for each facility in the array described in 3, above. The trended cost that is associated with the mid-point of the total patient days is determined by multiplying the total patient days by fifty percent (50%) and interpolating to determine the median cost. The cost at the median is multiplied by 110% to determine the ceiling.

5. Determine the per diem rate for each facility for direct care costs, therapies, care related costs and administrative and operating costs. If the facility's cost is above the ceiling, its rate is the ceiling. If the facility falls below the

ceiling, then its rate is its trended cost plus fifty percent (50%) of the difference between the trended cost or the median, whichever is greater, and the ceiling.

B. Property Payment. A per diem payment will be made for property costs based on a fair rental system. The amount of the payment is determined as follows:

1. A new facility constructed on January 1, 1992 is assumed to have a per bed value of $31,090, which is the per bed value of a nursing facility multiplied by one hundred twenty percent (120%). The value of new construction of a nursing facility bed will be indexed each year using the RS Means Construction Cost Index. The indexed value of new construction of a nursing facility bed will be multiplied by one hundred twenty percent (120%). The new bed value will be indexed each year to January 1 of the payment year using an estimated cost index calculated using a five-year moving average of the most recent cost indices for Jackson, Mississippi.

2. Existing facilities, one year or older, will be valued at the new construction bed value less depreciation of 1% per year according to the age of the facility. Facilities will not be depreciated to an amount less than 30% of the new construction bed value. Facilities which were constructed in one year and then added additional beds in later years will be valued based upon the original construction date for the original beds and the added beds will be valued based upon their construction date.

3. The per bed value will be multiplied by the number of beds in the facility to estimate the facility's total current value.

4. A rental factor will be applied to the facility's total current value to estimate its annual fair rental value. The rental factor is determined by using the Treasury Securities Constant Maturities (10-year) as published in the Federal Reserve Statistical Release using the average for the second calendar year preceding the beginning of the rate period with an imposed lower limit of seven and one-half percent (7.5%)

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

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

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

7. The total of the fair rental per diem payment and the per diem property taxes and insurance is the per diem property payment.
8. The hold harmless provision for capital costs must be computed as described in Chapter 6 of this plan to determine the per diem hold harmless payment for each facility.

C. Return on Equity Payment

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

and those assets and liabilities which are not related to the provision of patient care. Providers that are members of chain operations must also include in their working capital a share of the equity capital of the home office.

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

a. Property, plant, and equipment, excluding vehicles;
b. Debt related to property, plant, and equipment, excluding vehicles;
c. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
d. Notes and loans receivable from owners or related organizations;
e. Goodwill;
f. Unpaid capital surplus;
g. Treasury Stock;
h. Unrealized capital appreciation surplus;

i. Cash surrender value of life insurance policies;

j. Prepaid premiums on life insurance policies;

k. Assets acquired in anticipation of expansion and not used in the provider's operations or in the maintenance of patient care activities during the rate period;

l. Inter-company accounts;

m. Funded depreciation;

n. Cash investments that are long term (six months or longer);

o. Deferred tax liability attributed to non-allowable tax expense;

p. Any other assets not directly related to or necessary for the provision of patient care;

q. Net capitalized loan/financing costs;

r. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;

s. Workmen's Compensation self insurance fund.

D. Total Rate

The annual rate is the sum of the per diem rate for direct care costs, therapies, care related costs and administrative and operating costs, the per diem property payment, the per diem hold harmless payment, and the per diem return on equity payment.

E. Calculation of the Rate For One Provider

In years when the rate is calculated for only one facility, reimbursement will be based upon allowable reported costs of the facility. Reimbursement for direct care, therapies, care related, and administrative and operating costs will be made at cost plus the applicable trend factor. The property payment and the return on equity payment will be calculated for the facility as described in Sections 5-2 B. and C. The one provider will be subject to the hold harmless provisions of Chapter 6.

CHAPTER 6

HOLD HARMLESS FOR CAPITAL COSTS

6-1 Computation of Hold Harmless for Capital Costs

A computation will be made to determine if a facility is eligible for the hold harmless provision for capital costs in the initial rate period of this plan (FY 1994). For each rate period after FY 1994, the facility must have been eligible for the hold harmless provision in the prior rate period for this provision to apply in the current rate period. The computations will be made as follows:

1. Compute the facility's fair rental per diem payment related to property, plant, and equipment; as described in Section 3-4, E,5. This computation will exclude the pass through costs of property taxes and property insurance.
2. Compute the amount of allowable capital costs per day, excluding the pass through costs of property taxes and property insurance. Allowable capital costs include amortization expense-capital; interest expense-capital; and depreciation and rent on buildings, furniture, and equipment from the cost report.

3. When the amount computed in 2, above, exceeds the amount computed in 1, above, a facility will be considered for the hold harmless provision.

4. Determine if the facility's total allowable costs per day exceed or fall below the maximum rate for their classification as computed under the Medicaid State Plan in effect on June 30, 1993, hereafter referred to as the "old plan", except excluding the use of the trend factor.

5. Facilities with total allowable costs per day below the maximum rate for their classification, as computed in #4 above, will receive a hold harmless amount equal to the amount by which allowable capital costs per day (#2.) exceed the fair rental per diem payment related to property, plant, and equipment (#1.).

6. Facilities whose total allowable costs per day exceed the maximum rate for their classification, as computed in #4 above, will be subject to imposed limitations. These facilities will be subject to a hold harmless payment limit of up to $2.00 per patient day. Furthermore, allowable capital costs per day (as computed in #2 above) will be reduced by the pro-rata share of allowable capital per diem costs to total allowable per diem costs for purposes of comparing costs to the fair rental per

diem payment related to property, plant, and equipment. For example:

This example is based on information reported on the facility's calendar year 1992 cost report and computes the hold harmless provision for the facility for the rate period beginning July 1, 1993 and ending June 30, 1994 (FY 1994).

ABC Nursing Facility's computed fair rental per diem payment related to property, plant, and equipment is $7.50. The amount of allowable capital costs per day excluding the pass through costs of property taxes and property insurance is $10.25. The allowable capital costs of $10.25 exceed the computed fair rental per diem payment of $7.50; therefore, the facility is eligible for the hold harmless provision. The maximum rate for their classification as computed under the old plan, excluding the use of the trend factor for FY 1994 is $59.50.

1st Scenario:
ABC Nursing Facility's total allowable costs per day are $54.50. Thus, ABC Nursing Facility's allowable costs per day fall below the maximum rate for their classification by $5.00. The facility will be eligible to receive a hold harmless per diem amount equal to the difference between the allowable capital costs of $10.25 and the computed per diem rental payment of $7.50 or $2.75 per day in FY 1994. Therefore, ABC Nursing Facility will receive $2.75 per day for the hold harmless provision under this scenario.

2nd Scenario:
ABC Nursing Facility's total allowable costs per day are $63.50. Thus, ABC Nursing Facility's allowable costs per day exceed the maximum rate for their classification by $4.00. The facility will be subject to the hold harmless provision limitations as follows:

The allowable capital costs per day of $10.25 must be reduced by the pro-rata share of the amount which exceeds the maximum rate. The pro-rata share is determined by

dividing capital costs of $10.25 by total costs of $63.50. The pro-rata share of the excess costs over the maximum rate for ABC Nursing Facility is 16.14% of the excess of $4.00 or $0.65. Subtracting $0.65 from $10.25 results in the difference of $9.60 which is the allowable capital costs to be compared to the fair rental per diem payment related to property, plant, and equipment of $7.50. ABC Nursing Facility is eligible for hold harmless in the amount of $2.10 per day. The eligible amount is limited to the maximum of $2.00. Therefore, ABC Nursing Facility will receive $2.00 per day for the hold harmless provision under this scenario.

The ABC Nursing Facility, in subsequent rate periods, will apply the hold harmless dollar amount computed for FY 1994, unless the difference between actual costs and the fair rental per diem payment is less than the amount computed for FY 1994. The hold harmless provision in future years will be the lesser of the difference between actual costs and the fair rental per diem payment or the amount computed for FY 1994.

6-2 Documentation Required for Hold Harmless Eligibility

In order to be eligible for the hold harmless provision, a facility must submit with each cost report documentation that describes why the facility is unable to lower their property costs. This may include a copy of the facility's mortgage that disallows early payments, bonds that can not be refinanced, leases, etc. Failure to submit documentation will disqualify a facility from eligibility for the hold harmless provision.

6-3 Disqualification From Hold Harmless Provision

The list of occurrences by the provider listed below will also disqualify a facility from being eligible for the hold harmless provision for capital costs.

A. A change of ownership that occurs on or after July 1, 1993. Transactions that were binding prior to passage of enabling legislation for this plan that were not closed until after July 1, 1993 will not result in disqualification from eligibility for the hold harmless provision for capital costs.

B. Refinancing the mortgage(s) on the facility, except for refinancing 100% of the balloon principal payment due.

C. Negotiation of a new lease on or after passage of enabling legislation for this plan.

D. The per diem rental payment exceeds the actual per diem capital costs.

Once a facility does not qualify for the hold harmless provision for capital, it has lost all future eligibility for the provision.

CHAPTER 7

TREND FACTORS

7-1 Trend Factor - General Principles

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

7-2 Trend Factor Computation

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

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

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

1. Facilities which have at least eighty percent (80%) occupancy.

2. Facilities which are in operation a full twelve (12) months. Facilities which have undergone a change of ownership will be used if the facility was open at least twelve (12) months under both the buyer's and seller's periods of operations combined. The costs from all cost reports in the standard reporting year will be used in the computation.

3. Nursing facilities which either certify additional beds or decertify beds that results in a change in classification (either Small Nursing Facility to Large Nursing Facility or vice versa) as long as the facility was in operation at least twelve (12) months under both classifications combined. The costs from all cost reports in the standard reporting year will be used in the computation.

4. Facilities which use the cost report line(s) for allocated costs will not be used.

B. Computation of the Trend Factors

The following steps will be taken to compute the trend factors for direct care costs, therapies, care related costs and administrative and operating costs.

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

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

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

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

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

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

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

7-3 Trend Factors - Nursing Facilities

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

NURSING FACILITY TREND FACTORS - 2004

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

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

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

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

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

PRTF and ICF-MR TREND FACTORS – 2004

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

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

7-5 Mid-Point Factor

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

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

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

7-6 Market Basket of Economic Indicators Example

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

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

7-7 Trend Factor Computation Example

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

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

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

CHAPTER 8

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Small Nursing Facility - A classification of long term care facilities which provides nursing facility care in accordance

with 42 CFR Part 483, Subpart B and which has 1 - 60 beds certified for Title XIX.

Private Nursing Facility for the Severely Disabled

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