Reimbursement and Cost Report Changes: Training for Long-Term Care (LTC) Providers

Effective January 1, 2015

(to be used for Calendar Year 2015 Rates, Pending CMS Approval)

MISSISSIPPI DIVISION OF MEDICAID

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Background

- Pursuant to 2012 Legislation House Bill 421, Section 5, the Division of Medicaid (DOM) requested legislative approval to implement changes to the current reimbursement methodology for nursing facilities (NF), psychiatric residential treatment facilities (PRTF), and intermediate care facilities for individuals with intellectual disabilities (ICF/IID), effective January 1, 2015, pending CMS approval. In addition, DOM requested approval to make payment for ventilator dependent residents using a separate per diem rate. Compositely, these changes are expected to be near **budget neutral**.
- The 2012 Mississippi Legislature passed House Bill 421, Section 5, with a directive to DOM to do the following:
  - develop a plan providing revisions to the current reimbursement methodology, and
  - not implement these plans, but submit to the Legislature

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

- In response to the directive , DOM held an open forum meeting in June, 2012, and a workgroup was formed, comprised of the LTC industry representatives, DOM staff, other state agencies, consultants and other interested parties.
- The workgroup met multiple times in Jackson between July 2012 and November 2013 to develop recommendations and reimbursement models for consensus.
- The resultant consensus report, Mississippi Division of Medicaid, 'Nursing Facility Reimbursement Methodology Revision Report' was presented to the Mississippi Legislature in January 2014.
- During the 2014 Legislative Session, House Bill 1275 authorized DOM to make changes in the reimbursement methodology for all LTC facilities.

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LTC Reimbursement Changes:

- **Incontinence Supplies** – classified as care related expenses instead of administrative and operating expenses beginning with 2013 cost reports
- **Asset Additions Capitalization Policy Change** – increase asset capitalization from $500 to $5,000 and above (consistent with Medicare)
- **Return on Equity (ROE)** – decrease the ROE return rate from 9.50% to 5.75%
- **Ventilator Dependent Care (VDC)** – a separate per diem rate for ventilator dependent residents in approved nursing facilities
- **Durable Medical Equipment (DME)** – revision to DME to cover customized wheelchairs and not cover ventilator equipment
- **Fair Rental Value (FRV)** – update the components used in the computation of the FRV calculation for the property rate
- **NF Case Mix Calculations and System Processing** – implement the Resource Utilization Grouper (RUG) IV classification system
- **Access Incentives –** are no longer used in the case mix calculation

Reimbursement and Cost Report Changes - LTC

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Effects of Changes:

Incontinence Supplies (e.g., underpads and diapers)

- Previously recorded as Administrative & Operating (A&O) costs on cost report Form 6, Line 4-36
- Effective with the 2013 cost report filings, and going forward, **must be reported in Care-Related section on Line 3-21**
- Preparers/facilities were given notice during 2014 to make this change on their 2013 cost reports by reclassifying such costs from A&O to Care-Related
- DOM made the reclassification on desk reviews for facilities identified as reporting on the incorrect cost report line
- Applicable revisions to the 'Instructions for Filing Long-Term Care Facility Cost Reports' will be revised for Line 3-21 and Line 4-36. The updates will be posted on DOM's website

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Asset Additions Capitalization Policy Change

- Previously asset additions capitalization threshold was "greater than $500"
- Effective with 2013 cost reports and January 1, 2015 rates, the **capitalization threshold (policy) is $5,000 and abov**e (consistent with Medicare)
- In 2014, DOM provided preparers '2013 Form 7 – APPENDIX A' with instructions to complete in addition to the standard 'Form 7, Page 2 of 2', to make the transition to the new policy
- Some preparers made the appropriate entries to increase Line 4-37 for additions "less than $5,000" and removed the related depreciation expense from Form 6. DOM made the entries for those that did not, if the facility completed APPENDIX A.

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- Preparers should take note that the asset additions "less than $5,000" for 2013 and forward should not be included on their depreciation schedules or included in depreciation expense on Form 6 in the current and future cost report filings.
- The '2013 Form 7 – APPENDIX A' is only applicable for the 2013 period ending cost reports and should not be used for any cost reports filed for periods after that year.
- Preparers must record their "$5,000 and above" asset additions for each calendar year including and following 2013 on Form 7, Page 2 of 2. Individual items costing "less than $5,000" should be expensed to Line 4-37 ("Miscellaneous").

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Return on Equity (ROE) –

- The previous "Authorized Rate of Return" used for ROE on your cost report (and DOM desk review) was 9.50% (Form 13, Line 7).
- Effective with the 2014 cost report filings, and going forward, **the "Authorized Rate of Return" to be used on your cost report (and DOM desk review) is 5.75%**.
- Most preparers filed their 2013 reports using the 9.50% rate. DOM also prepared its 2013 desk reviews using that rate, but will utilize the new 5.75% rate for ROE in the 2015 rate calculations (pending CMS approval)
- DOM will not issue an amended desk review Form 13 for this change

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Ventilator Dependent Care (VDC) Costs - Approved NFs

- For **nursing facilities (NFs) only,** that have been **approved for ventilator dependent care services**, costs above the normal and necessary care of nursing facility residents for VDC will be allowed and reported on the cost report
- These VDC costs must be reported on a new addendum titled, "Form 6 Addendum, Ventilator Dependent Care (VDC) Expenses", which will be updated to the cost report forms on the DOM website

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Effective January 1, 2015, Pending CMS Approval

- A daily rate for VDC in addition to the standard per diem
- VDC costs will include, but are not limited to:
  - VDC salaries of RT's, LPN's & RN's
  - VDC fringe benefits
  - Training of VDC staff
  - VDC medical supplies
  - Rental of VDC medical equipment and supplies
- The **reimbursement rate** has been pre-established at **$178.34** per VDC patient day and will be billed and paid separately from the facility's standard rate

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Ventilator Dependent Care Costs (VDC) – (cont.)

- This rate was determined based on data reviewed from various states with VDC payment, including rates, staffing and other costs for approved VDC services
- Effective with the 2014 cost report filings for facilities providing approved VDC services, the 'Form 6 Addendum – Ventilator Dependent Care (VDC) Expenses' will be required to report all the additional costs of the VDC services
- The Form 6 Addendum must be filed along with the standard Form 6, and supported by a segregated or identifiable VDC trial balance of expenses and reclassification and adjustment schedules, if applicable

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Effective January 1, 2015, Pending CMS Approval

- Utilization of the specific Form 6 Addendum to capture VDC costs will provide the resources to conduct a trend analysis of the costs to determine if an adjustment is warranted in the future
- VDC costs **will not** be used to calculate the standard per-diem rate

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Durable Medical Equipment (DME) –

- Ventilators in NFs will no longer be reimbursed through DME. NFs approved by DOM to provide VDC services will be reimbursed for the rental of ventilators and their supplies are included in the VDC per diem rate.
- DOM is updating the Miss. Administrative Code Part 207, Chapter 2: Nursing Facility, Rule 2.6, Per Diem for nursing facility and adding a new Rule 2.15, Ventilator Dependent Care to include the provision of ventilator reimbursement.
- New rules for NF and ICF/IID will address Individualized, Resident Specific Custom Manual and/or Custom Motorized Power Wheelchairs…at Chapter 2, Rule 2.18 and Chapter 3, Rule 3.10, respectively.

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Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Durable Medical Equipment (DME) – (cont.)

Reimbursed outside the Medicaid per diem rate; billed by a separate provider with a separate provider number. Now includes:

Customized Wheelchairs – "individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident"

DOM **does not** classify (1) standard manual wheelchairs, (2) standard manual wheelchairs with added accessories, (3) standard motorized wheelchairs, and/or (4) standard motorized power wheelchairs with added accessories as DME.

Reimbursement and Cost Report Changes - LTC

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Effects of Changes (cont.):

Revision to 'Instructions for Filing Long-Term Care Facility Cost Report' & 'Cost Report'

- 'Instructions …', **page 22, Line 3-21, Supplies – Care Related** – description revise to include incontinence supplies **(underpads, diapers, etc.)**
- 'Instructions …', **page 27, Line 4-28, Depreciation** - delete verbiage, "on or after January 1, 1992" and revise applicable instances of "$500" (threshold) to "$**5,000 or greater**"
- 'Instructions …', **page 28, Line 4-36, Linen and Laundry Alternative**s, - delete verbiage, "underpads and diapers (reusable and disposable)"
- 'Instructions …', **page 31, Line 5-02, Depreciation** - delete verbiage, "over $500" and revise with "$**5,000 or greater**"

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Effects of Changes (cont.):

Revision Drafts to 'Instructions for Filing Long-Term Care Facility Cost Report' & 'Cost Report'

- 'Instructions …', **page 56, FORM 6 'ADDENDUM'** - add instructions for the completion of new Form 6
- 'Cost Report' - add new **Form 6 Addendum, Ventilator Dependent Care (VDC) Expenses** for reporting of ventilator care services
- Post both revised "Instructions For Filing Long-Term Care Facility Cost Report" and revised "Cost Report Forms" on DOM's website by February 1, 2015

MDS RUG IV

MDS RUG IV, effective January 1, 2015, pending CMS approval

- DOM Using *RUG IV – 48 Group, Set F01, Nursing Only CMS standard weights RUG IV used to calculate 3rd Quarter, 2014 rosters forward
- Case Mix indices (CMI) are based upon Facility-wide Case-Mix
- RUG IV CMI used to neutralize 2013 base year direct care costs using facility wide RUG IV CMI from 2013 cost report period (i.e. RUG IV on annual reports)
- Alzheimer's Weights based on differential for RUG III weights applied to RUG IV*

MDS RUG IV

- MDS RUG IV Training was recently held for all nursing facilities
- MDS Facility 2014 - 3rd Quarter Roster Schedule

  1st Interim Roster posted electronically by Myers & Stauffer (M&S), November 4

  2nd Interim Roster to be posted November 11

  Quarter Closes – November 14

  Final 3rd Quarter and Annual Rosters to be posted November 20
- Bedhold and corrections should be submitted electronically to M&S and will be posted each quarter
- Nursing facilities will continue to input bedhold information in the Envision system through November 14, 2014, the quarter close date. Beginning November 15, 2014, NF will begin using the new M&S Web Portal to input bedhold data.

MDS RUG IV

- Contact M&S, effective November 1, 2014
  - Case Mix Roster Reports (800-773-8609)
  - Transmission deadlines of rosters mshelpdesk@mslc.com
  - Medicaid Resources www.mslc.com/mississippi
  - CMS User ID/Passwords QTSO Help Desk (800-339-9313)
  - CMSNET user ID/Passwords (888-238-2122)

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

Draft Administrative Code Minimum Requirements

- Complete Provider Enrollment Addendum with Medicaid including on-site approval of services by Department of Health, Licensure & Certification
- Provider ensures via addendum:
  - Number of beds designated for ventilator dependent services
  - Required staffing ratios will be met
  - Agreement with local hospital for emergency care of all ventilator dependent residents

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

NF/VDC MUST PROVIDE:

- Required staffing ratios will include 24/7 nursing and respiratory therapy designated to VDC services only as follows:
- Available 24/7 – 1 RN 1:10 ventilator residents **and**
  - 1 RT 1:10 ventilator residents
  - 1 RN and 1 LPN 11-14 residents
  - 2 RNs for 15-20 residents
  - 1 RN primary responsibility available 24/7
- Nurse aides assigned to resident must be trained in ventilator care
- Maintain separate staffing records for ventilator services
- Excludes licensure staffing requirements

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

- Adequate equipment and supplies
- Physician visits (per state & federal requirements)
- Audible, redundant external alarm system outside resident's room
- Policy and procedures including infection control
- Staff education and in-service training to VDC staff at onset of delivering services & on-going per Administrative Code, Title 23, Part 207, Chapter 2, Nursing Facility, Rule 2.15, Ventilator Dependent Care

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

VDC ADMISSIONS MUST BE PRIOR AUTHORIZED BY MEDICAID OR DESIGNEE

- Meet Resident Medicaid Eligible Requirements
- Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day **OR** continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process
- Require daily respiratory intervention, e.g., oxygen therapy, chest physiotherapy or deep suctioning

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

- Medically stable & not require acute care services for 2 weeks prior to transfer/admission to nursing facility
- Provide documentation of continued medical necessity and weaning attempts
- Does not include BIPAP OR C-PAP residents

VENTILATOR DEPENDENT CARE (VDC)RESIDENTS IN NF

REIMBURSEMENT:

- Established per diem rate of $178.34

- Claim must be filed with dates of service for VDC billed with specific Revenue Code (projected to be Revenue Code 0194)

- Claim will be paid tied to Prior Authorization #, Beneficiary ID, dates of service and Revenue Code

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Rate Changes

- Ventilator Rate
- RUG IV changes
- Fair Rental Changes
- Return On Equity

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

- The pre–established Vent Rate is $178.34. The Vent Rate was determined based on data reviewed from various states with VDC services, including rates, staffing and other costs for approved VDC services
- The VDC rate will be paid through the claims system under an approved revenue code and prior authorization code for approved VDC nursing facilities
- The VDC rate will not be listed on the facility rate sheet
- The pre-established Vent rate will be reviewed every fifth year to determine reasonable reimbursement based on actual costs

Projected Rate Example

DIVISION OF MEDICAID
NURSING FACILITY REIMBURSEMENT METHODOLOGY EFFECTIVE JANUARY 1, 2015
RUG III vs. RUG IV Example

	Facility XYZ	USING RUG III		USING RUG IV	
a.	Direct Care Per Diem Reported Cost	$ 61.50		$ 61.50	
b.	Case-Mix Score for Cost Report Period (Annual)	1.449		1.056	
c.	Case-Mix Adjusted Direct Care Per Diem Cost (a / b)	$ 42.44		$ 58.25	
d.	Care Related Per Diem Reported Cost	$ 24.61		$ 24.61	
e.	Case Mix Adjusted Direct Care & Care Related Per Diem Reported Cost (c + d)	$ 67.05		$ 82.86	
f.	Direct Care & Care Related Trend Factor + 1	1.0186		1.0186	
g.	Trended Direct Care and Care Related Per Diem (e x f)	$ 68.30		$ 84.40	
h.	Direct Care & Care Related Per Diem Ceiling	$ 93.61		$115.68	
i.	Direct Care & Care Related Per Diem Standard Rate (lesser of g or h)	$ 68.30		$ 84.40	
j.	Care Related Cost as a Proportion of Direct Care & Care Related (d / e)	36.70%		29.70%	
k.	Care Related Per Diem Rate (i x j)		$ 25.07		$ 25.07
l.	Direct Care Component of Per Diem Standard Rate (i - k)	$ 43.23		$ 59.33	
m.	Case Mix Score for Period: July 1, 2014 - September 30, 2014 (Quarterly)	1.371		0.999	
n.	Direct Care Per Diem Payment: (l x m)		$ 59.27		$ 59.27
o.	Total Direct Care & Care Related Per Diem Rate for the quarter:		$ 84.34		$ 84.34

The relationship of the annual roster to the quarterly roster will be the same. The reduction in scores due to the use of RUG IV will have no impact on payment. RUG IV will be used for both the annual and quarterly rosters.

A change in payment from the case mix score will be related to the discontinuance of the 2% access weights.

Reimbursement and Cost Report Changes - LTC

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Fair Rental Value

- Increase the value of nursing facility bed to $91,200
- Increase the annual depreciation amount from 1% to 1.75% for all long-term care facilities
- Increase the maximum allowed depreciation from 30% to 50% for all long term care facilities
- Decrease the rental factor from 7.5% to 5.35% while maintaining the 2% risk premium for all long-term care facilities
- Bed equivalents for renovations will be determined by dividing bed value by accumulated depreciation
- Maximum facility age is 30 years (depreciation limited to only 28.5714 years with 50% depreciation maximum)

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

- The bed values for LTC Facilities effective January 1, 2013, for January 1, 2015, rate setting are:

  Nursing Homes - $91,200

  ICF-IID's & PRTF's - $91,200

  NF – Severely disabled - $159,600

- Along with the change in bed value, calculation of renovation costs/beds will change. Effective for January 1, 2015 rate setting accumulated depreciation will be utilized to determine new bed equivalents.

Renovation New Bed Equivalent Examples

Existing System

100 Bed Facility			
Cost of Renovation	$ 500,000		
New Bed Value	$ 91,200		
New Bed Equivalent	**5.48**		
	Number of Beds	Age	Weighted Average Age
Existing Beds	94.52	20	1,890
New Bed Equivalent	5.48	0	-
Total Beds	100		18.90

Impact on FRV Value-Assume 1.75% Depreciation/Year

	Value Before Renovation	Value After Renovation	Difference
New Bed Value	$ 9,120,000	$ 9,120,000	
Depreciation	$ (3,192,000)	$ (3,017,000)	
Rental Value	$ 5,928,000	$ 6,103,000	**$ 175,000**

The FRV value increases only $175,000 although the renovation cost was $500,000. Only 35% of the cost is recognized in the new FRV value which is exactly equal to the percentage that the property has been depreciated at the time of the renovation

New System

100 Bed Facility			
Cost of Renovation	$ 500,000		
Accumulated Depreciation per Bed at Time of Renovation	**$ 31,920**		
New Bed Equivalent	**15.66**		
	Number of Beds	Age	Weighted Average Age
Existing Beds	84.34	20	1,687
New Bed Equivalent	15.66	0	-
Total Beds	100		16.87

Impact on FRV Value-Assume 1.75% Depreciation/Year

	Value Before Renovation	Value After Renovation	Difference
New Bed Value	$ 9,120,000	$ 9,120,000	
Depreciation	$ (3,192,000)	$ (2,692,000)	
Rental Value	$ 5,928,000	$ 6,428,000	**$ 500,000**

The FRV value increases $500,000, exactly equal to the renovation cost of $500,000

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

- Effective January 1, 2015, the new bed equivalent is cost of renovation divided by the accumulated depreciation per bed at time of renovation..
- Example: Facility consists of 100 beds. Cost of Renovation is $500,000. Bed Value = $91,200. The Cost of Renovation $500,000 divided by the Accumulated Depreciation per Bed at Time of renovation ($91,200 x 1.75% (depreciation) x 20 (years) = $31,920. $500,000/$31,920 = 15.66 New bed equivalent.
- Total Beds 100 – New Bed Equivalent 15.66 = Existing Beds 84.34. Existing Beds 84.34 x 20 years = 1,687 / 100 beds = 16.87 weighted average age.

Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

- Value Before Renovation: New Bed Value $91,200 x 100 beds = $9,120,000 – Depreciation (20 Years x .0175 depreciation x 9,120,000 New Bed Value) 3,192,000 = $5,928,000.
- Value After Renovation: New Bed Value $$91,200 x 100 beds = $9,120,000 – Depreciation (9,120,000 x .0175 depreciation x 16.87 weighted average) 2,692,000 =6,428,000.
- Rental Value After Renovation $6,428,000 – Rental Value before $5,928,000 = $500,000.
- The FRV value increases $500,000, exactly equal to the renovation of cost of $500,000

1992		0	0				0	0	0
1991			0				0	0	0
1990			0				0	0	0
1989			0				0	0	0
1988			0				0	0	0
1987			0				0	0	0
1986			0				0	0	0
1985			0				0	0	0
1984			0				0	0	0
1983			0				0	0	0
1982			0				0	0	0
1981			0				0	0	0
1980			0				0	0	0
1979			0				0	0	0
1978			0				0	0	0
1977			0				0	0	0
PRE '77			0				0	0	0
TOTAL	100	0	100		0	0	100	0	100

	XYZ Nursing Home							
	PROVIDER NO.		12345678					

	MAJOR IMPROVEMENT / RENOVATION COSTS						
	M'CAID	OTHER	TO BE		ADJUSTED AMOUNTS		
YEAR	DIRECT		ALLOC.	TOTAL	M'CAID	OTHER	TOTAL
2016				0	0	0	0
2015	500,000			500,000	500,000	0	500,000
2014				0	0	0	0
2013				0	0	0	0
2012				0	0	0	0
2011				0	0	0	0
2010				0	0	0	0
2009				0	0	0	0
2008				0	0	0	0
2007				0	0	0	0
2006				0	0	0	0
2005				0	0	0	0
2004				0	0	0	0
2003				0	0	0	0
2002				0	0	0	0
2001				0	0	0	0
2000				0	0	0	0
1999				0	0	0	0
1998				0	0	0	0
1997				0	0	0	0
1996				0	0	0	0
1995				0	0	0	0
1994				0	0	0	0
1993				0	0	0	0

XYZ Nursing Home

PROVIDER NO. 12345678

FAIR RENTAL SYSTEM AGE WEIGHTING COMPUTATION

YEAR	PER BED CONSTR. VALUE	QUALIFIES FOR NEW BEDS ?	RENOVATION / IMPROV. BEDS	FAIR RENTAL ADJUSTED BEDS	AGE IN YEARS	WEIGHTED AVERAGE
2016						
2015	91,200	YES	15.66	15.66		0
2014	91,200		0	0	1	0
2013	91,200		0	0	2	0
2012	52,954		0	0	3	0
2011	50,700		0	0	4	0
2010	50,999		0			
2009	52,622		0			
2008	47,552		0			
2007	40,759		0			
2006	38,174		0			
2005	36,617		0			
2004	32,475		0			
2003	32,210		0	0	12	0
2002	31,911		0	0	13	0
2001	31,315		0	0	14	0
2000	31,016		0	0	15	0
1999	30,663		0	0	16	0
1998	29,858		0	0	17	0
1997	28,818		0	0	18	0
1996	28,233		0	0	19	0
1995	27,604		0	84.34	20	1686.8
1994	26,750		0	0	21	0
1993	26,300		0	0	22	0

Administrator:
Qualifies if improvement cost is greater than or equal to new bed value of 91,200

Administrator:
If the renovated cost is greater than or equal to the new bed value then the renovation cost is divided by the minimum of accumulated depr. Or a maximum of 30 years bed age. 500,000 / (91,200 x .0175 x 20) or max 30 years facility age.

1992	25,908			0	23	0
1991	25,473			0	24	0
1990	25,052			0	25	0
1989	24,558			0	26	0
1988	24,152			0	27	0
1987	23,629			0	28	0
1986	23,165			0	29	0
1985	22,700			0	30	0
1984	22,367			0	30	0
1983	22,294			0	30	0
1982	20,726			0	30	0
1981	19,565			0	30	0
1980	17,983			0	30	0
1979	16,343			0	30	0
1978	15,182			0	30	0
1977	14,006			0	30	0
PRE '77	13,019			0	30	0
TOTAL				100		1686.8

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PROPERTY RA1E CALCULATION:

B.	Rental Factor	5.35%		
C.	Risk Factor	2.00%		
D.	Annualized Patient Days (Certified)	29,200		
E.	2015 Bed Value	91,200		
F.	Depreciated Bed Value-Max of (E-(A•.0175)E) or (SE)		$64,275	
G.	Total Nursing Fadlity Value (Total # of Beds • F)		$6427,548	
H.	Gross Rental Value (G • (B+C))		$472,425	
I.	Gross Rental Per Diem Payment (H I D)			$16.18!
J.	Annualized Property Insurance	$10 400		
K.				
	Annualized Property Taxes	$40000		
L.	Property Tax and Insurance Per diem Payment ((J + K) / D)			$1.73

The Minimum of the weighted average age divided by the fair rental adjusted beds or 28.5174 years. (28.5714 x .0175 -, s0%

The Max of either 2015 bed value minus the depr o/o of .0175 X the weighted

f the 2015 bed value facility age in years or 50% o

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Reimbursement and Cost Report Changes - LTC

Effective January 1, 2015, Pending CMS Approval

Return on Equity

- Return on equity reduced from 9.5% to 5.75%
- Takes effect on the January 1, 2015, Rate Sheets

REMINDERS

Form 1 - Section I, II, III, IV & V

- **Section I –** Make sure all information is correct, current, (Facility Name, Provider Number, D/B/A, Email Address, Contact Person etc….) and updated for changes to the provider's administrator or correspondence person
- **Section II –** Complete this section only if the facility is filing an amended cost report. The reason for the amendment must be clearly stated and each cost report form being amended must be marked "AMENDED" at the top of each form and applicable support document. Each amended cost report must include Forms 1 and 2 as well as the applicable forms and schedules being amended
- **Section III –** Complete this section if the General Ledger of the Medicaid-certified nursing facility also accounts for other entities. Examples of other entities are hospital, rural health clinic, outpatient therapy services, non-Medicaid certified nursing facility and personal care home

REMINDERS

Form 1 Section I, II, III, IV & V (cont.)

- Section IV – Complete this section if the facility employs a home office or a related management company. In addition, facilities claiming home office costs/related management fees must complete Form 17; and Schedules 11 and 12. Facilities with a Home Office must complete a Form 18
- Section V – Complete this section if the facility employs a management company. A narrative description of purchased management services or a copy of contracts for managed services must be submitted with the cost report in order for management fees to be allowed

REMINDERS

Form 3 - Line 2 D

- Please check blocks on Line 2 D, Column 1 so that all entity types reported in the general ledger are marked “yes”. Columns 2, 3, 4 and 5 must be completed if “yes” is marked in Column 1
- Column 1 – check yes if the entity type is reported in the general ledger
- Column 2 – enter the number of patient days related to the particular use of the facility
- Column 3 – enter the number of beds related to the particular use of the facility
- Column 4 – enter the square footage related to the particular use of the facility

REMINDERS

Form 5

- Column 1 & 2 **MUST** be completed

Form 6

- Providers are required to complete a separate adjustment & reclass schedule to tie to Form 6, Columns 2 & 4.

Form 11

- the working trial balance provided by the provider should tie to Form 11, Column 2 entries

REMINDERS

Form 15 – Sections VII & VIII

- Section VII - Compensation paid to an employee who is an immediate relative of an owner, officer of director should report **ONLY** the hours work at or on behalf of the facility in the column labeled "Average Hours Worked Per Week"
- Section VIII (A) – Indicate the estimated AVERAGE number of hours worked by the owner, officer or director in the facility and time away from the facility that is related to management of the facility

REMINDERS

Form 17

- Section 2 – Column 1 – this column must agree with the general ledger of the home office or the management company
- Section 2 – Column 2 – this column must include adjustments made to remove expenses not related to patient care, revenues offset against expenses, and expenses directly related to **all** facilities
- Section 2 – Column 3 – expenses that are directly related to management of the facility for which the cost report is being filed must be reported on Column 3

REMINDERS

Form 17 (cont.)

- Section 2 – Column 4 – Column 1 less Column 2 must be reported in Column 4. These are the expenses to be allocated to all facilities managed by the home office or the management company
- Section 2 – Column 5 – Column 4 multiplied by the allocation percentage related to the facility for which the cost report is being filed must be reported in Column 5
- Section 3, Line 3-03 – Total allowable expenditures reported on this Line should tie to Form 6, Line 4-38, Column 5
- Section 4 – the provider(s) need to provide a brief description of the method used to allocate expenses to the necessary facility or facilities as well as show the allocation calculation used

REMINDERS

Form 17 (cont.)

- A copy of the working trial balance must be submitted to support each Form 17. A copy of an amortization schedule and depreciation schedule must be submitted to support costs reported on Lines 2-10 & 2-13

Bed Tax

- Provide support for the bed tax charged on Form 6, Line 4-43

Medicare Cost Report

- Provide all supplemental information to support the allocations of the home office to the necessary facility or facilities

REMINDERS

**Although supplemental information is required to support the cost report, ALL forms and schedules must be completed in their entirety

QUESTIONS

Contacts

- **Cost Report:** T. J. Walker email: t.j.walker@medicaid.ms.gov
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- **Case Mix/RUG IV:** Gail Townsend: gail.townsend@medicaid.ms.gov