State of Mississippi

DESCRIPTIONS OF LIMITATION AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4a. Nursing Facility Services:

The Division of Medicaid covers Nursing Facility services provided in a facility licensed and certified by the state survey agency as a Medicaid Nursing Facility and meets all the requirements in 42 CFR Part 483.

A Nursing Facility is defined as an institution, or distinct part thereof, that meets the requirements of Sections 1919(a), (b), (c) and (d) of the Social Security Act. The Nursing Facility primarily provides the following three (3) types of services and is not primarily for the care and treatment of mental diseases:

1. Skilled nursing care and related services for residents who require medical or nursing care,

2. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

3. Health-related care and services on a regular basis to individuals with mental or physical conditions requiring care and services that can only be made available through institutional facilities.

A nursing facility must provide, or arrange for, nursing or related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as outlined in 42 CFR Part 483.

State of Mississippi

DESCRIPTIONS OF LIMITATIONS AS TO AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

15. Intermediate Care Facilities for Individuals with Intellectual Disabilities

The Division of Medicaid covers Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) that meet the requirements of the State and 42 CFR Part 483.

According to Section 1905(d) of the Social Security Act, ICF/IIDs are defined as institutions, or distinct part thereof, for individuals with intellectual disabilities or persons with related conditions in which the facilities primary purpose is to provide health or rehabilitative services and provide active treatment as defined in 42 CFR Part 483 in the least restrictive setting. Services must be provided in a protected residential setting and must include ongoing evaluations, twenty-four (24) hour supervision, and coordination and integration of health or rehabilitative services to help each individual function at his/her greatest ability.

STATE OF MISSISSIPPI

OFFICE OF THE GOVERNOR

DIVISION OF MEDICAID

STATE PLAN

GUIDELINES FOR THE REIMBURSEMENT

FOR MEDICAL ASSISTANCE

BENEFICIARIES OF

LONG TERM CARE FACILITIES

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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 beneficiaries. 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 beneficiaries. 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 Centers for Medicare and Medicaid Services Minimum Data Set Resident Utilization Group IV, Set F01, 48-Group, Nursing Only (MDS RUG IV). 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 beneficiaries. 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), Nursing Facilities for the Severely Disabled (NFSD), Psychiatric Residential Treatment Facilities (PRTF), and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

1-3 Cost Reporting

A. Reporting Period

All Nursing Facilities, PRTFs, and ICF/IIDs 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 period 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;
4. 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.
6. Work papers that support the ventilator dependent care unit form, if applicable.

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 thirty-six (36) 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 standard year end or other approved year end, as outlined in Section 1-3, A. The cost report must cover a reporting period of at least one month, defined as beginning on or before the fifteenth day of the month. If needed, to comply with this requirement, the initial cost report may cover up to thirteen months.

The cost report for the old owner, used in setting the old owner's rate just prior to the effective date of the change of ownership, will be used to set the base rates of the new owner until such time that the new owner's initial cost report is used under the regular rate setting schedule. Asset additions will be incorporated into the property rate using the regular schedule each January 1. Adjustments to the old owner's cost report otherwise required under this plan will apply to the new owner (i.e. audit adjustments, trend factors). The new owner's initial cost report will be used to rebase the new owner's rate for the second calendar year following the end of the initial cost report.

Example for January 1, 2013 Change of Ownership:

Effective Date	Base Rate	Cost Report Used	Trend Multiplier
December 31, 2012	$174.00	Calendar year 2010	2.0
January 1, 2013	$179.00	Calendar Year 2010	3.0
January 1, 2014	$182.00	Calendar Year 2010	4.0
January 1, 2015	$185.00	Calendar year 2013	2.0

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 increaseor 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/IIDs 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/IIDs and PRTFs 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, PRTFs and ICF/IIDs from states other than Mississippi may file claims for services provided to Mississippi Medicaid beneficiaries 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/IIDs and PRTFs 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 NFs 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/IIDs and PRTFs 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/IIDs, 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. The resident trust fund accounts of each facility will be reviewed annually. 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 MDS RUG IV group than the MDS RUG IV 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 reviews, 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:

1. Failure to disclose or make available to the Division of Medicaid, or its authorized agent, records of services provided to Medicaid beneficiaries and records of payment made therefrom.
2. Failure to provide and maintain quality services to Medicaid beneficiaries within accepted medical community standards as adjudged by the Division of Medicaid or the MS Department of Health.
3. 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.

4. Documented practice of charging Medicaid beneficiaries for services over and above that paid by the Division of Medicaid.
5. 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.
6. Failure to meet standards required by State or Federal law for participation.
7. Submission of a false or fraudulent application for provider status.
8. Failure to keep and maintain auditable records as prescribed by the Division of Medicaid.
9. Rebating or accepting a fee or portion of a fee or charge for a Medicaid patient referral.
10. Violating a Medicaid beneficiary's absolute right of freedom of choice of a qualified participating provider of services under the Medicaid program.
11. Failure to repay or make arrangements for the repayment of identified overpayments, or otherwise erroneous payments.
12. Presenting, or cause to be presented, for payment any false or fraudulent claims for services or merchandise.

13. Submitting, or causing to be submitted, false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.
14. Submitting, or causing to be submitted, false information for the purpose of meeting prior authorization requirements.
15. Exclusion from Medicare because of fraudulent or abusive practices.
16. 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.
17. Failure to submit timely and accurately all required resident assessments.
18. 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.
19. Non-compliance with requirements for the management of beneficiaries' personal funds, as stated in 42 CFR, Section 483.10, and as hereafter amended.
20. 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:

1. Suspension, reduction, or withholding of payments to a provider,
2. 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.
3. Suspension of participation in the Medicaid Program,

   and/or
4. 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 beneficiaries, their families or any other third party.

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 beneficiaries 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 beneficiary 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.

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/IID 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 beneficiaries 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/IID 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.

a. Administrative and Operating Depreciation Expense.

Assets purchased on or after January 1, 2013, excluding vehicles, for an amount of $5,000 or greater but collectively 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/IIDs, or Chapter 5 for PRTFs 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 should be depreciated using the straight line method over three (3) to five (5) years. These depreciation expenses should be included in Administrative and Operating Costs on the cost report.

b. Property and Equipment Depreciation Expense.

Assets purchased on or after January 1, 2013, excluding vehicles, for an amount of $5,000 or greater and collectively equal to or greater than the new bed value determined for the year of the purchase, as defined by other portions of this plan, should be considered as either new beds, replaced beds, or a renovation. These depreciation expenses should be included in Property and Equipment Costs on the cost report.

c. Shared Assets.

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 is combined with assets solely to the certified beds for comparison to the new bed value for type of depreciation expense determinations. 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.

d. Assets less than $5,000.

Assets purchased for an amount less than $5,000 should be included in allowable costs as a current period expense.

Additionally, the portion of assets allocated to the certified unit for less than $5,000 should be expensed in the current period.

The expense should be included in the Miscellaneous Administrative and Operating Costs on the cost report.

e. Facility depreciation.

A facility may choose to depreciate an asset that cost less than $5,000 or was allocated at less than $5,000. In these cases, the Division of Medicaid will not adjust the depreciation expense nor enter an adjustment to allow the asset expense. Additionally, the capitalized asset will not be used for comparison to the new bed value to determine depreciation type. Only assets greater than or equal to $5,000 are used for the comparison.

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 beneficiaries.

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

supplements; materials and supplies for the operation, maintenance and repair of buildings, grounds and equipment; 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 NFSD, PRTF and ICF/IID 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.

21. Medicaid Assessment. The nursing facility, ICF/IID and PRTF assessments referred to in Section 43-13-145, (1), (2), and (3), Mississippi Code of 1972, as amended, will be considered allowable costs on the cost report filed by each long-term care facility, in accordance with the CMS Provider Reimbursement Manual, Part 1, Section 2122.1.

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, CMS Publication 15-1, 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 beneficiaries 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/IID 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 NFSD less than the maximum rate, administrative and operating costs of less than the maximum rate, 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 and Bed Hold Days Information.

Assessments of all residents must be submitted electronically in accordance with CMS requirements. Bed hold days information must be submitted electronically to the Division of Medicaid’s designee.

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. Bed Hold days, which are therapeutic leave and hospital leave 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 will affect the case mix computation using the start date of the assessment except for new admissions and reentries. The computation of the facility's case mix score will use the date of admission for new admissions or residents that are reentered after a discharge from the facility. In computing a facility's average case mix, the dates of admission or reentry will be counted and the dates of discharge will not be counted in the computation.

C. Medicaid Reviews of the MDS. The accuracy of the MDS will be verified by Registered Nurses. At least ten percent (10%) of the total facility beds 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 beneficiaries 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 reviews of the MDS, the sample selection process, and the acceptable error rate. If MDS data is not available, the Division may temporarily cease performing reviews.

D. Roster Reports. Roster reports are used for reporting each beneficiary's MDS RUG classification with assigned case mix index (CMI) for all days within the report period. Bed hold days are reflected on the roster reports. The facility's weighted average index, or score, is also reported. Roster reports are run for each calendar quarter (quarterlies) and for each cost report period (annuals). The annual rosters are used to set base per diem rates each January 1. The quarterlies are used in setting the direct care per diem rate each quarter. Roster reports are made available to all facilities electronically. Interim roster reports should be checked by the facilities to confirm assessments completed by the facility have been submitted to the QIES ASAP System used by the Division of Medicaid case mix database and to confirm discharge assessments are reflected on the report. Facilities should also use the interim roster reports to confirm all hospital and home/therapeutic leave has been properly reported. Missing assessments, discharge assessments, and bed hold days information should be submitted electronically prior to the close of the quarter. If the quarter close date is on a weekend, 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.

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E. Failure to Submit MDS Forms. Nursing facilities that do not submit the MDS for residents for which an assessment was due and completed, transmitted electronically and accepted, the period beginning day 91 is considered an inactive assessment or expired assessment period. The days following an expired assessment (starting the 91st day) will be assigned the delinquent RUG classification of BC1, Inactive Category, with a CMI of 0.450, 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 Inactive classification of BC1. Delinquent assessments are defined as those assessments not completed according to the schedule required by CMS and the Division of Medicaid.

3-3 Resident Classification System

The Division of Medicaid uses the MDS RUG IV classification model to classify nursing facility 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 RUG IV model contains forty-eight (48) total groups and is based on index maximizing; ranging from the most resource intense to the least resource intense. (The graphic depiction of the classification hierarchy included at the end of this section provides a visual representation of this narrative.)

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

Extensive Services
Rehabilitation Special Care
High
Special Care Low
Clinically Complex
Behavioral Symptoms and Cognitive Performance
Reduced Physical Functioning

These seven (7) major categories split into additional groupings based on specific criteria; namely the Activities of Daily Living (ADL) Score, Depression Severity Score, and Restorative Nursing Programs, each of which is described below.

The Inactive Category is defined in 3-2, E. as for delinquent or expired assessments.

ADL Score

The ADL Score 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 RAI User's Manual. The ADL score is **NOT** a total of the actual ADL codes on the MDS. A score is assigned to show how a resident functions in Self Performance and Support Provided in the following manner:

For **Bed Mobility, Toilet Use, and Transfer**, residents who are coded as:

- Independent or needing Supervision receive a score of 0
- Needing Limited Assistance receive a score of 1
- Requiring Extensive Assistance with no physical assist, setup assist or 1 person physical assist receive a score of 2
- Requiring Total Dependence with no physical assist, setup help or 1 person physical assist receive a score of 3
- Requiring Extensive Assistance or Total Dependence with 2+ person physical assist receive a score of 4

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

- Independent, needing Supervision or Limited Assistance with or without setup help only receive a score of 0
- Independent, needing Supervision or Limited Assistance with 1 or 2+ person physical assist receive a score of 2
- Requiring Extensive Assistance or Total Dependence with no setup help or physical help from staff or setup help only receive a score of 2
- Requiring Extensive Assistance with 1 or 2+ person physical assist receive a score of 3
- Requiring Total Dependence with 1 or 2+ physical assist receive a score of 4

The ADL Score may range from a low of zero (0) to a high of sixteen (16). The following example illustrates how an ADL Score 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 Score would be computed as follows:

-Bed mobility (independent)	= 0
-Toilet use (extensive assistance with 1-person assist)	= 2
-Transfer (limited assistance) 11	= 1
-Eating (independent)	= 0
ADL Score	**3**

The ADL Score is an extremely important component of all classifications, providing the final determination of the MDS RUG IV group (Note: the exceptions are in the major categories of Extensive Services, Special Care High, Special Care Low, and Behavioral Symptoms and Cognitive Performance where a resident must meet an ADL Score requirement before being classified into those categories). An ADL Score is calculated for all assessments.

Depression Groups

The major categories of Special Care High, Special Care Low and Clinically Complex have 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: The presence and frequency of symptoms of depression are determined by a standardized severity score greater than or equal to 10. The Total Severity Score is derived from responses to items contained in the PHQ-9© Resident interview or the **PHQ-9-0V**© Staff Assessment of Mood.

Restorative Nursing Groups

Three of the major categories have splits which indicate the receipt of restorative nursing programs. The major categories for which this split applies are Rehabilitation, Behavioral Symptoms and Cognitive Performance, and Reduced Physical Function. In order to be computed as receiving Restorative Nursing, a resident must receive two (2) restorative nursing programs, each for at least six (6) days a week and a minimum of fifteen (15) minutes a day. Restorative Nursing includes the techniques/practices specified in the MDS.

In an index maximized classification system, assessments are sorted from those having the highest acuity*I* 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 ADL score, Depression Severity Score and/or Restorative Nursing Program is determined, and the final group classification is made.

An additional group classification is included to allow placement of assessments that become delinquent or inactive. This group classification (BCl,) is given the same weight as the lowest group classification.

The classification will be calculated electronically at the Division of Medicaid or its designee using the MDS assessment and the MDS RUG IV classification model. Submission requirements are addressed in section 3-2(A).

Each of the forty-eight (48) resident group classifications as well as the inactive/expired classifications have been assigned case mix weights. The base weights for all classification groups 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.

CMS MEDICAID PAYMENT INDEX
MDS RUG IV, SET F01, NURSING ONLY
48 Group Classification Model

EXTENSIVE SERVICE CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
ES3 Extensive Services	2-16	3.000	
ES2 Extensive Services	2-16	2.230	
ES1 Extensive Services	2-16	2.220	

REHABILITATION CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
RAE Rehabilitation	15-16	1.650	
RAD Rehabilitation	11-14	1.580	
RAC Rehabilitation	6-10	1.360	
RAB Rehabilitation	2-5	1.100	
RAA Rehabilitation	0-1	0.820	

SPECIAL CARE HIGH CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
HE2 Special Care High with Depression	15-16	1.880	
HE1 Special Care High	15-16	1.470	
HD2 Special Care High with Depression	11-14	1.690	
HD1 Special Care High	11-14	1.330	
HC2 Special Care High with Depression	6-10	1.570	
HC1 Special Care High	6-10	1.230	
HB2 Special Care High with Depression	2-5	1.550	
HB1 Special Care High	2-5	1.220	

SPECIAL CARE LOW CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
LE2 Special Care Low with Depression	15-16	1.610	
LE1 Special Care	15-16	1.260	
LD2 Special Care Low with Depression	11-14	1.540	
LD1 Special Care Low	11-14	1.210	
LC2 Special Care Low with Depression	6-10	1.300	
LC1 Special Care Low	6-10	1.020	
LB2 Special Care Low with Depression	2-5	1.210	
LB1 Special Care Low	2-5	0.950	

CLINICALLY COMPLEX CATEGORIES

GROUP DESCRIPTION	ADL SCORE	MISSISSIPPI WEIGHT	
		REGULAR	ALZHEIMER'S
		UNIT	UNIT
CE2 Clinically Complex with Depression	15-16	1.390	1.779
CE1 Clinically Complex	15-16	1.250	1.600
CD2 Clinically Complex with Depression	11-14	1.290	1.651
CD1 Clinically Complex	11-14	1.150	1.472
CC2 Clinically Complex with Depression	6-10	1.080	1.382
CC1 Clinically Complex	6-10	0.960	1.229
CB2 Clinically Complex with Depression	2-5	0.950	1.216
CB1 Clinically Complex	2-5	0.850	1.088
CA2 Clinically Complex with Depression	0-1	0.730	0.934
CA1 Clinically Complex	0-1	0.650	0.832

BEHAVIORAL SYMPTOMS AND COGNITIVE PERFORMANCE CATEGORIES

GROUP DESCRIPTION	ADL SCORE	CMI	
		REGULAR	ALZHEIMER'S
		UNIT	UNIT
BB2 Behavioral Symptoms and Cognitive Performance with Restorative Nursing	2-5	0.810	1.393
BB1 Behavioral Symptoms and Cognitive Performance	2-5	0.750	1.290
BA2 Behavioral Symptoms and Cognitive Performance with Restorative Nursing	0-1	0.580	0.998
BA1 Behavioral Symptoms and Cognitive Performance	0-1	0.530	0.912

REDUCED PHYSICAL FUNCTION CATEGORIES

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
PE2 Reduced Physical Function with Restorative Nursing	15-16	1.250	1.600
PE1 Reduced Physical Function	15-16	1.170	1.498
PD2 Reduced Physical Function with Restorative Nursing	11-14	1.150	1.472
PD1 Reduced Physical Function	11-14	1.060	1.357
PC2 Reduced Physical Function with Restorative	6-10	0.910	1.165
PC1 Reduced Physical Function	6-10	0.850	1.088
PB2 Reduced Physical Function with Restorative	2-5	0.700	0.896
PB1 Reduced Physical Function	2-5	0.650	0.832
PA2 Reduced Physical Function with Restorative	0-1	0.490	0.627
PA1 Reduced Physical Function	0-1	0.450	0.576

INACTIVE CATEGORY

		CMI	
		REGULAR	ALZHEIMER'S
GROUP DESCRIPTION	ADL SCORE	UNIT	UNIT
BC1 Inactive Group*	Not Applicable	0.450	0.450

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

3-4 Computation of Standard Per Diem Rate for Nursing Facilities

A standard per diem base rate will be established annually, unless this plan requires a rate being calculated at another time, for the period January 1 through December 31. 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 base 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. For example, the base rates effective January 1, 2015 will be determined from cost reports filed for the year ended June 30, 2013 for state owned facilities, for the year ended September 30, 2013 for county owned facilities and for the year ended December 31, 2013 (or other approved year-end) for all other facilities, unless a short period cost report and rate calculation are 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 case mix 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 1.000.
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 for direct care and care related costs together for small and large nursing facilities and separately for NFSD’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 NFSD’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%).

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

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

9. The 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 B, below, on a quarterly basis.

B. 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 direct care base rate will be multiplied by its average case mix for the period two calendar quarters prior to the start date of the rate being calculated. For example, the January 1, 2015 rate will be determined by multiplying the direct care base rate by the average case mix for the quarter July 1, 2013 through September 30, 2013. 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 NFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, and the per diem return on equity capital to compute the facility's total standard 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 NFSD's only, the administrative and operating per diem rate, the per diem fair rental payment, 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 made 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.

C. Therapy Rate for 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 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.

D. 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. 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 NFSDs, the ceiling for Administrative and Operating Costs will be the facility's allowable costs.

E. Property Payment.

1. The property payment includes the fair rental per diem and the property taxes and insurance per diem. The fair rental per diem is a rental payment based on the age of each facility. The property taxes and insurance per diem is based on actual facility costs.

The fair rental system establishes a facility's value based on its age. The newer the facility is aged, the greater its value. The facility specific value and fair rental per diem are determined using the following parameters:

a. State-wide new bed value
b. Medicaid certified beds at the start of the rate period
c. Facility average age, not to exceed 28.5714 years
d. Accumulated depreciation, accumulating at a rate of 1.75% annually, not to exceed 50%
e. Rental factor of 5.35% with an added risk factor of 2%
f. Annualized patient days, at no less than 80% occupancy

The new bed value minus the accumulated depreciation multiplied by total beds determines the facility value. The value times the rental factor divided by days equals the fair rental per diem. The parameters and calculations are further described below.

2. Each year a state-wide new bed value is determined. The new bed value for 2015 is $91,200. Therefore, a new facility constructed during 2015 will have a per bed value of $91,200 for the 2015 rental payment. 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, 2016 through December 31, 2016, the 2015 new bed value will be adjusted to the January 1, 2016 value using the estimated index. An adjustment to the new bed value of 37.20% will be made for beds in licensed Alzheimer's units based on the additional construction costs required to be licensed as an Alzheimer's unit. Likewise, an adjustment of 175% will be made to the nursing facility new bed value for NFSDs.

The new bed value for Mississippi has been rebased effective January 1, 2015. The previous new bed values apply for rate setting periods prior to January 1, 2015. For transition purposes, $91,200 will be used for determining if 2013 and 2014 capitalized assets and renovation costs will be converted into new beds. The list of historical new bed value indices is included in 9.

3. The Medicaid certified beds at the start of the annual rate period will be used for the property rate calculation. An 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.

4. Each facility's average age is a weighted average of each certified bed within the facility. The beds are aged using their construction date and adjustments for additions, replacements, and renovations and major improvements as defined by this plan. Additions, replacements, and renovations and major improvements will be recognized by lowering the age of the facility and, thus, increasing the facility's value. The facility average age will not exceed 28.5714 years for purposes of the fair rental calculations. Beds constructed during the rate setting year will be considered to have a zero (0) age. All beds will be aged by one (1) year at each December 31. Beds will not be aged beyond thirty (30) years for calculating new bed equivalents.

a. The addition of beds is typically accomplished through construction or the conversion of personal care or hospital beds. Newly constructed beds are aged in the year placed in service. Converted beds will be assigned the average age of the Medicaid-certified beds calculated for the 1992 start-up of the fair rental system. If the converted beds were aged for start-up, however, the related computation will be used. The cost of renovations and major improvements after start-up and before conversion will be considered in aging the beds if the facility provides proper documentation at the time of the conversion.

b. The replacement of existing beds differs from the addition of beds in that a certain number of beds replace those that were previously aged. Unless the replaced beds can be specifically identified on the property rate sheet, it is assumed that the oldest beds are the ones replaced.

c. Renovations and major improvements reduce the average age of the facility by bringing a calculated number of beds' aging to the year of renovation or major improvement. Renovation and major improvement costs include all capitalized assets greater than or equal to $5,000, excluding vehicles. The 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. Costs capitalized by a facility lessor are considered. In facilities with distinct parts, renovation and/or major improvement costs are limited to the portion of capitalized assets allocated directly and indirectly to the classification being considered. The indirect allocation for assets shared between the certified beds and the other beds in the facility are based on the number of beds in the classification being considered to total facility beds at year end.

In establishing the age of a facility, renovations/improvements are converted into bed replacements when the renovations/improvements in the aggregate exceed the new bed value. The conversion is made by dividing the total cost by the average accumulated depreciation per bed at January 1st of the renovation year.

d. The start-up age of each facility bed will not exceed thirty (30) years.

5. Accumulated Depreciation. Facilities, one year or older, will be valued at the new construction bed value less depreciation of 1.75% per year according to the age of the facility. The average accumulated depreciation per bed is calculated by multiplying the new bed value by the average age of the facility and by the 1.75% depreciation rate. Facilities will not be depreciated to an amount less than fifty percent (50%) of the new bed value. For sales of assets closed on or after July 1, 1993, there will be no recapture of depreciation.
6. Facility Value. The average per bed value is the difference between the new bed value and the accumulated depreciation. The average per bed value will be multiplied by the number of beds to estimate the facility's total current value.
7. A rental factor is 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 5.35% 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%) is added to the index value. The rental factor is multiplied by the facility's total current value to determine the annual fair rental value.
8. The annual fair rental value is divided by annualized total patient days to calculate the fair rental per diem. Annualized patient days will equal the total patient days for Medicaid certified beds reported for the cost report period used to set the rate. An adjustment to annualize the days will be made if the cost report period is not equal to twelve months. 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 being used to set rates. Patient days will be adjusted to at least 80% occupancy, if the facility reported an occupancy rate lower than 80%.

9

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

CALENDAR YEAR		NEW CONSTRUCTION VALUE PER BED
1992		$25,908
1993		$26,300
1994		$26,750
1995		$27,604
1996		$28,233
1997		$28,818
1998		$29,858
1999		$30,663
2000		$31,016
2001		$31,315
2002		$31,911
2003		$32,210
2004		$32,475
2005		$36,617
2006		$38,174
2007		$40,759
2008		$47,552
2009		$52,622
2010		$50,999
2011		$50,700
2012		$52,954
2013	For Renovations only	$91,200
2014	For Renovations only	$91,200
2015	Rebased	$91,200

MS PROPERTY REIMBURSEMENT - FAIR RENTAL SYSTEM EXAMPLE

Per Bed Value of New Nursing Facility

$91,200 (including building, land and equipment) on January 1, 2015.

Per Bed Value of Specific Facility (Based on Annual Depreciation for age of Facility)

Depreciation of new bed value at 1.75% per year based on year of construction or bed replacement, not to exceed 50% of the new bed value. Individual beds will not be aged beyond 30 years and the facility average age will not exceed 28.5714 years.

Example: Facility Constructed in 2010 has depreciated 5 years.
Depreciation: 1.75% x 5 = 8.75%.
Depreciated bed value: $91,200 x 91.25% (100%-8.75%) = $83,220.

Facility's Total Current Value

Per Bed Value x Number of Beds

Example: 120 Bed Facility Value = $83,220 x 120 = $9,986,400

Rental Factor

Federal Reserve Treasury Securities Constant Maturities (10yr) + Risk Premium

Example: Rental Factor = 5.35% + 2.0% = 7.35%

Annual Fair Rental Value

Facility Value x Rental Factor

Example: Rental Value = $9,986,400 x 7.35% = $734,000

Fair Rental Per Diem

Rental Value/Annualized Total Patient Days

Example: Rental Payment = $734,000/41610 = $17.64

Property Taxes and Insurance Per diem

Pass Through Based on Annualized Reported Costs/Annualized Total Patient Days

Example:	Property Taxes	$0.65 ($27,050/41,610)
	Cost report Form 6, line 5-05	
	Prop. Insurance	0.60 ($24,970/41,610)
	Cost report Form 6, Line 5-04	
	Total	$1.25

Per Diem Property Payment

Rental Payment + Taxes & Insurance
Example: Per Diem Property Payment = $17.64 + $1.25 = $18.89

F. 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 return on equity (ROE) factor 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. The return on equity factor is five and seventy-five hundredths percent (5.75%).

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:

1. Property, plant, and equipment, excluding vehicles;
2. Debt related to property, plant, and equipment, excluding vehicles;
3. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
4. Notes and loans receivable from owners or related organizations;
5. Goodwill;
6. Unpaid capital surplus;
7. Treasury Stock;
8. Unrealized capital appreciation surplus;

9. Cash surrender value of life insurance policies;
10. Prepaid premiums on life insurance policies;
11. 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;
12. Inter-company accounts;
13. Funded depreciation;
14. Cash investments that are long term (more than six months);
15. Deferred tax liability attributed to non-allowable tax expense;
16. Any other assets not directly related to or necessary for the provision of patient care;
17. Net capitalized loan/financing costs;
18. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;
19. Workers' Compensation self-insurance fund.

Return on Non-Property Equity Per Diem

*Average Non-Property Equity x ROE Factor / Annualized Total Patient Days

Example:

Avg. Non-Property Equity=$156,500 x 5.75% (ROE factor)/41,610 = $.22

*Subject to limitation of two (2) months of reported allowable costs

G. Total Standard Per Diem Rate. The annual standard per diem rate is the sum of the direct care per diem rate, the care related per diem rate, the administrative and operating per diem rate, the per diem property payment, and the per diem return on equity payment. The annual rate for NFSD's also includes the therapy per diem rate.

H. Calculation of the Rate for One Provider. In years when the rate is calculated for only one NFSD, 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. 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 Ventilator Dependent Care (VDC) Per Diem Rate

A ventilator dependent care (VDC) per diem rate of $178.34 is established for beneficiaries receiving VDC services in large and small nursing facilities. The VDC per diem rate will be reviewed for adjustment every fifth year.

3-6 Occupancy Allowance

The per diem rates for fixed administrative and operating costs, care related costs and property costs wi11 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 (20,000/70%)

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

3-7 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.

3-8 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.

3-9 Upper Payment Limit (UPL)

Non-state government owned and operated NF's will 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 payments actually made by Medicaid during that same time period. The calculation will be made as follows: MDS data is run for a sample population of each facility to group patient days into one of the Medicare RUGs. 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 will 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. 100 percent of the calculated UPL will be paid to non-state government-owned or operated facilities, in accordance with applicable state and federal laws and regulations, including any provisions specified in appropriations by the Mississippi Legislature.

State government owned or operated NF's will 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 payments actually made by Medicaid during that same time period. The calculation will be made as follows: For each State provider, total Medicaid allowed amounts and total covered days including bed hold are obtained from the provider's most current Medicaid cost report after desk review. In addition total Medicaid bed hold patient days will be obtained from the MMIS. For each provider the allowed amount per day is calculated by dividing the Medicaid allowed amounts per cost report by the total covered days per cost report less bed hold days. The allowed amount per day is multiplied by paid Medicaid days less bed hold days per the MMIS to determine the upper payment limit on Medicaid payments. The upper payment limit on Medicaid payments is then compared to the actual Medicaid payments made during that same time period to calculate the available UPL balance for each facility. This calculation will then be used to make payment for the current period to nursing facilities eligible for such payments in accordance with applicable regulations regarding the Medicaid upper payment limit. 100 percent of the calculated UPL will be paid to State government owned or 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/IID'S

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

It is the intent of the Division of Medicaid to reimburse Intermediate Care Facilities for Individuals with Intellectual Disabilities 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 and an occupancy rate of 80% or more.

4-2 Computation of Rate for Intermediate Care Facilities for Individuals with Intellectual Disabilities

A per diem rate will be established annually 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 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, 2015 will be determined from cost reports filed for the cost report year ended in 2013 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-IID and PRTF Trend Factor. This is done by multiplying the ICF-IID and PRTF Trend Factor in order to trend costs forward from the

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, 2015 is assumed to have a per bed value of $91,200, which is 100 percent of the nursing facility bed value. The value of new construction of a nursing facility bed 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 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 bed value less depreciation of 1.75% per year according to the average age of the facility. Facilities will not be depreciated to an amount less than 50% of the new bed value. Additions, replacements and renovations and major improvements will be aged and converted to new beds as described for nursing facilities in Chapter 3.

3. The per bed value is multiplied by the number of certified beds 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 five and thirty-five hundredths percent (5.35%) 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.

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 return on equity (ROE) factor 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. The return on equity factor is five and seventy-five hundredths percent (5.75%). 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 there with, 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:

1. Property, plant, and equipment, excluding vehicles;
2. Debt related to property, plant, and equipment, excluding vehicles;
3. Liabilities related to property, plant, and equipment, excluding vehicles, such as accrued property taxes, accrued interest, and accrued property insurance;
4. Notes and loans receivable from owners or related organizations;
5. Goodwill;
6. Unpaid capital surplus;
7. Treasury Stock;

8. Unrealized capital appreciation surplus;
9. Cash surrender value of life insurance policies;
10. Prepaid premiums on life insurance policies;
11. 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;
12. Inter-company accounts;
13. Funded depreciation;
14. Cash investments that are long term (six months or longer);
15. Deferred tax liability attributed to non-allowable tax expense;
16. Any other assets not directly related to or necessary for the provision of patient care;
17. Net capitalized loan/financing costs;
18. Resident fund accounts held on behalf of the resident which were included on the facility's balance sheet;
19. 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, and the per diem return on equity payment.

E. State Owned ICF-IID's

ICF-IID'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 ICF-IID may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned ICF-IID'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.

F. 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.

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, 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.

However, the PRTF rates effective January 1, 2010, will continue to be effective through June 30, 2012, for facilities in operation as of August 25, 2010. For facilities initially Medicaid certified between August 25, 2010 and June 30, 2012, the per diem base rate effective the first day of certification, computed in accordance with this plan subject to January 1, 2010 ceilings, will be used as the base rate through June 30, 2012. No adjustments to the rate, otherwise required by this plan, will be used to determine PRTF rates after January 1, 2010 and before July 1, 2012, except that rates will be adjusted to incorporate facility cost changes related to the provider tax limit increase effective October 1, 2011.

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 in1, above, to the middle of the rate year using the ICF-IID and PRTF Trend Factor. This is done by multiplying the ICF-IID 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, 2015 is assumed to have a per bed value of $91,200 which is 100 percent of the per bed value of a nursing facility. The value of new construction of a nursing facility bed 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 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 bed value less depreciation of 1.75% per year according to the average age of the facility. Facilities will not be depreciated to an amount less than 50% of the new construction bed value. Additions, replacements, and renovations and major improvements will be aged and converted to new beds as described for nursing facilities in Chapter 3.

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 five and thirty-five hundredths (5.35%).

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.

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 return on equity (ROE) factor 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. The return on equity factor is five and seventy-five hundredths percent (5.75%). 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:

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

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

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

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

5. Goodwill;

6. Unpaid capital surplus;

7. Treasury Stock;

8. Unrealized capital appreciation surplus;

9. Cash surrender value of life insurance policies;

10. Prepaid premiums on life insurance policies;

11. 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;

12. Inter-company accounts;

13. Funded depreciation;

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

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

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

17. Net capitalized loan/financing costs;

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

19. 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, and the per diem return on equity payment.

E. State Owned PRTF[1]s

PRTF[1]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 PRTF may request that the per diem rate be adjusted during the year based on changes in their costs. After the state owned PRTF[1]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.

F. 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.

CHAPTER 6

TREND FACTORS

6-1 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.

6-2 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 6-6 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 6-7 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.

6-3 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 6-2. 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	6.13%	77.93%	4.78%
Care Related	61,417,034	4.15%	22.07%	0.92%
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 6.13% and the trend factor for care related costs was determined to be 4.15% in the trend factor computation example shown in Section 6-7, computed in accordance with Section 6-2. 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 (6.13% X

77.93%) + (4.15% 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%.

6-4 Trend Factor – PRTF's and ICF/IID's

One (1) trend factor will be used in computing the rates for PRTF's and ICF-IID'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-IID 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-IID trend factor. For example:

PRTF and ICF-IID TREND FACTORS – 2004

Cost Center	Allowable Costs	Trend Factor	% of Total Costs	Adjusted Trend Factor
Direct Care	$216,911,547	6.13%	44.83%	2.75%
Therapies	17,048,995	6.32%	3.52%	0.22%
Care Related	61,417,034	4.15%	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-IID Trend Factor is 6.91%.

6-5 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 6-3 and 6-4, the

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

6-6 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	1-06, 2-06, 3-08, 4-11	278.8	292.9	5.1%
SAA	Apparel	Uniform Allowance	1-09, 2-09, 3-11, 4-14	127.3	124	-2.6%
SAM1	Medical Care Commodities	Drugs	1-14	247.6	256.4	3.6%
		Medical Supplies	1-15			
SEHG02	Garbage and Trash Collection	Medical Waste Disposal	1-16	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	1-17	186.1	190.5	2.4%
		Therapy Supplies	2-15			
		Supplies - Care Related	3-21			
		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, 1-04, 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	1-05, 2-05, 3-07, 4-10	222.5	236.7	6.4%
	PERS rate change with wage index	Pensions	1-07, 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	1-10, 2-10, 3-12, 4-15	136.8	145.5	6.4%
	Wage Index	Unemployment Tax	1-08, 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%

6-7 Trend Factor Computation Example

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
1	**DIRECT CARE COSTS**				
1-01	Salaries-Aides	89,848,420	41.42%	6.40%	2.65%
1-02	Salaries-LPN's	49,940,472	23.02%	6.40%	1.47%
1-03	Salaries-RN's (exclude DON & RAI Coord.)	21,223,437	9.78%	6.40%	0.63%
1-04	Salaries-Feeding Assistants	1,833,641	0.85%	6.40%	0.05%
1-05	FICA-Direct Care	12,576,700	5.80%	6.40%	0.37%
1-06	Group Insurance-Direct Care	10,377,862	4.78%	5.01%	0.24%
1-07	Pensions-Direct Care	598,697	0.28%	6.40%	0.02%
1-08	Unemployment Taxes-Direct Care	1,011,299	0.47%	6.40%	0.03%
1-09	Uniform Allowance-Direct Care	413,085	0.19%	-2.60%	0.00%
1-10	Workmen's Comp-Direct Care	6,206,719	2.86%	6.40%	0.18%
1-11	Contract-Aides	6,437,412	2.97%	6.40%	0.19%
1-12	Contract-LPN's	1,520,643	0.70%	6.40%	0.04%
1-13	Contract-RN's	1,777,912	0.82%	6.40%	0.05%
1-14	Drugs - Over-the-Counter and Legend-VDC	4,005,160	1.85%	3.60%	0.07%
1-15	Medical Supplies	6,658,105	3.07%	3.60%	0.11%
1-16	Medical Waste Disposal	511,655	0.23%	2.70%	0.01%
1-17	Other Supplies-Direct Care	1,970,328	0.91%	2.40%	0.02%
1-18	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Direct Care Costs		$216,911,547	100.00%		6.13%
2	**THERAPY COSTS**				
2-01	Salaries-Occupational Therapists	306,165	1.80%	6.40%	0.12%
2-02	Salaries-Physical Therapists	431,249	2.53%	6.40%	0.16%
2-03	Salaries-Speech Therapists	261,529	1.53%	6.40%	0.10%
2-04	Salaries-Other Therapists	1,936,608	11.36%	6.40%	0.73%
2-05	FICA Taxes - Therapies	240,304	1.41%	6.40%	0.09%
2-06	Group Insurance-Therpapists	268,452	1.57%	5.01%	0.08%
2-07	Pensions-Therapists	66,130	0.39%	6.40%	0.02%
2-08	Unemployment Taxes-Therapists	21,455	0.13%	6.40%	0.01%
2-09	Uniform Allowance-Therapists	6,266	0.03%	-2.60%	0.00%
2-10	Workmen's Comp-Therapists	62,182	0.36%	6.40%	0.02%
2-11	Contract-Occupational Therapists	3,542,127	20.78%	6.40%	1.33%
2-12	Contract-Physical Therapists	4,386,198	25.73%	6.40%	1.65%
2-13	Contract-Speech Therapists	1,846,379	10.83%	6.40%	0.69%
2-14	Contract-Other Therapists	3,433,903	20.14%	6.40%	1.29%
2-15	Therapy Supplies	240,048	1.41%	2.40%	0.03%
2-16	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
Total Therapy Costs		$17,048,995	100.00%		6.32%

6-7 Trend Factor Computation Example

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
3	**CARE RELATED COSTS**				
3-01	Salaries-Activities	5,136,257	8.36%	6.40%	0.54%
3-02	Salaries-Assistant Director of Nursing	3,123,663	5.09%	6.40%	0.33%
3-03	Salaries- Director of Nursing	7,777,076	12.66%	6.40%	0.81%
3-04	Salaries-MDS Coordinator	4,013,640	6.54%	6.40%	0.42%
3-05	Salaries-Pharmacy	45,378	0.07%	6.40%	0.00%
3-06	Salaries-Social Services	4,687,317	7.63%	6.40%	0.49%
3-07	FICA Taxes-Care Related	2,061,706	3.36%	6.40%	0.22%
3-08	Group Insurance-Care Related	1,824,792	2.97%	5.01%	0.15%
3-09	Pension Plan-Care Related	376,240	0.61%	6.40%	0.04%
3-10	Unemployment Taxes-Care Related	155,099	0.25%	6.40%	0.02%
3-11	Uniforms-Care Related	112,715	0.18%	-2.60%	0.00%
3-12	Workmen's Comp-Care Related	922,489	1.50%	6.40%	0.10%
3-13	Barber & Beauty Expense-Allowable	345,793	0.56%	2.10%	0.01%
3-14	Consultant Fees-Activities	75,920	0.12%	2.70%	0.00%
3-15	Consultant Fees-Medical Director	1,725,043	2.81%	2.80%	0.08%
3-16	Consultant Fees-Nursing	1,477,260	2.41%	2.70%	0.07%
3-17	Consultant Fees-Pharmacy	646,320	1.05%	2.70%	0.03%
3-18	Consultant Fees-Social Worker	113,825	0.19%	2.70%	0.01%
3-19	Consultant Fees-Therapists	42,012	0.07%	2.70%	0.00%
3-20	Food	22,033,612	35.88%	1.80%	0.65%
3-21	Supplies-Care Related	4,720,877	7.69%	2.40%	0.18%
3-22	Allocated Costs-Hospital Based & State Facilities	0	0.00%	0.00%	0.00%
3-18	**Total- Care Related Expenses**	$61,417,034	100.00%		4.15%

Line No.	COST CENTER	Line Cost Item	Percentage of Cost Center	Trend Factor	Weighted Trend Factor
4	**ADMINISTRATIVE AND OPERATING**				
4-01	Salaries-Administrator	8,700,745	4.62%	6.40%	0.30%
4-02	Salaries-Assistant Administrator	577,088	0.31%	6.40%	0.02%
4-03	Salaries-Dietary	20,847,337	11.06%	6.40%	0.71%
4-04	Salaries-Housekeeping	10,928,029	5.80%	6.40%	0.37%
4-05	Salaries-Laundry	4,989,169	2.65%	6.40%	0.17%
4-06	Salaries-Maintenance	5,154,790	2.74%	6.40%	0.18%
4-07	Salaries-Medical Records	3,126,640	1.66%	6.40%	0.11%
4-08	Salaries-Other Administrative	13,928,346	7.39%	6.40%	0.47%
4-09	Salaries-Owner	1,135,719	0.60%	6.40%	0.04%
4-10	FOCA Taxes-Admin & Operating	5,331,387	2.83%	6.40%	0.18%
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 7

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 direct care 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.

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 Individuals with Intellectual Disabilities (ICF-IID) - A classification of long-term care facilities that provides services only for individuals with intellectual disabilities 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 Alzheimer 's Unit Weights – A calculation, based on actual time and salary information of the care givers, of the relationship of each RUG IV group to the average for residents in licensed Alzheimer's Units.

Resource Utilization Grouper IV (RUG IV)– The Centers for Medicare and Medicaid Services Medicaid 48-grouper classification system adopted for use in setting per diem rates for nursing facilities. 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 that 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 Psychiatric Residential Treatment Facilities (PRTF).

Patient Days- The number of days of care charged to a beneficiary, 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 beneficiaries, 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.

Psychiatric Residential Treatment Facilities- A classification of facilities that 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 that provides nursing facility care in accordance with 42 CFR Part 483, Subpart B and which has 1-60 beds certified for Title XIX.

Nursing Facility for the Severely Disabled- A classification of long-term care facilities that 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).