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

For facilities with costs allocated from hospitals, home offices and related management companies the listed information is required for all entities. All cost reports must be filed in electronic format, with the following:

1. Working Trial Balance, facility and home office (if applicable);
2. Grouping schedule showing the general ledger accounts grouped together and reported on the various lines of the cost report.
~~2~~3. 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~~4. Any work papers used to compute the reclassifications and adjustments made in the cost report(s);
~~4~~5. Narrative description of purchased management services or a copy of contracts for managed services, if applicable;

~~5~~6. Form 2 with an original signature on the Certification by Officer or Administrator of Provider. Scanned signatures are acceptable.

~~6~~7. 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

are adopted 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 the Section II; Form 2 with original signature; and all forms that are being amended along with work papers for any revised reclassifications and/or adjustments. 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 review 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.

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.~~
4. All desk reviews may be amended multiple times.
5. Desk reviews amended after the annual base rate is determined will be used only to adjust the individual provider's rates.
6. Desk reviews may not be the final determination of allowable costs used in the calculation of the provider's rate. All cost reports have the potential to be audited.

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 amended cost reports must be maintained for a period of three (3) years after the submission date of the amended cost report. 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 audit~~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. Information requested during an audit that is submitted after the provider's receipt of the Medicaid adjustment report will not be accepted. Providers will not be allowed to submit this information at a later date, 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.

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.

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. Accounting fees resulting from suits against federal and or state agencies administering the Medicaid program are not allowable costs and should not be claimed until all appeal remedies have been exhausted and the provider has prevailed~~s~~ in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these accou nting fees in the current cost report period open at that time.

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

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, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. These legal fees, expenses and costs shall be documented in the provider's file, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

Legal fees resulting from suits against federal and/or state agencies administering the Medicaid program are not allowable costs and should not be claimed until all appeal remedies have been exhausted and~~unless~~ the provider has prevailed~~s~~ in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these legal fees in the current cost report period open at that time.

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.

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' and Officer's Salaries. A reasonable allowance of compensation for services of ~~—~~owners and officers 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 or officer 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 or officer~~s~~ 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 or officers, 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 or officer —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 or officers average time worked which is less than forty hours per week. Owners and officers 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, ~~s~~ 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.

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 are allowable~~should be reported on Form 6, Line 2~~. Physical, Occupational and Speech Language Pathology t~~T~~herapy expenses will be included in the per diem rate for NFSD, PRTF and ICF/IID providers. Physical, Occupational and Speech Language Pathology t~~T~~herapy expenses for Small Nursing Facilities and Large ~~—~~Nursing Facilities will be reimbursed on a fee for service basis. Respiratory therapy expenses will be included in the per diem rate for all long-term care facilities.

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 monthly nursing facility, ICF/IID and PRTF bed assessments based on bed occupancy, ~~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.

22. Training Costs. Training costs, other than nurse aide training, are an allowable cost where the fees paid are (a) to maintain current license/certifications, (b) or directly applicable to your current position, and therefore related to patient care, or (c) for training on software updates. The~~se~~ costs are allowable in the cost report period incurred.

23. Educational costs to attain a college or technical degree resulting in the attainment of an increase in license level (e.g. CNA receiving an LPN, or RN degree or certification)– Costs of education of employees at accredited and technical institutions to acquire an undergraduate or graduate degree are allowable in accordance with the Provider Reimbursement Manual (PRM) 15-1 section 416.3 as modified by the following;

    The costs should not be claimed until the cost report period after the employee has attained their degree/certification. The costs should amortized over a similar number of periods for which tuition was paid or the continued employment agreement period (between the employee and the facility) whichever is longer. i.e. If 4 semesters of tuition were paid, then the expense should be spread over 2 years of a cost report period.

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.

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. Other Medicaid assessments

   a) Any portion of Medicaid Hospital assessments and IGTs, will be considered non-allowable costs on the cost report filed by each long-term care facility.

   b) Medicaid Assessments other than the monthly Medicaid LTC bed assessments based on occupancy, will be considered non-allowable costs on the cost report filed by each long-term care facility.

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, late payment fees 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.

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. Hospital Based Costs Allocation

1. For costs allocated from hospitals, the costs must be reasonable and necessary in the provision of patient care at the long-term care facility (LTC) providers. All cost allocation determinations must be in accordance with Chapters 21, 22 and 23 of PRM Publication 15-1.

2. Allocation of these costs must be in a manner that is auditable and that is supported by documentation that verifies the allocation of expense is applicable to the LTC facility for which services were rendered.

3. For LTC facilities that are not contiguous to the hospital, square footage or number of personnel is not an acceptable allocation statistic. Documented provision of service must be maintained related to the allocation of any cost center other than Administrative and General (A&G), which should be allocated on the accumulated cost basis. This documentation includes, but is not limited to, time or assignment schedules documenting the provision of service to the affected LTC facility.

4. As part of the allocation of the A&G cost center, only costs of those areas, included in the A&G center, that provided service to the attached LTC facility should be allocated to them.

~~1.~~5. Hospital providers are not mandated to componentize their A&G or other cost centers; but, should the hospital provider choose not to do so, any expenses allocated to the LTC facility contrary to the instructions in items 1-4 above should be calculated and removed before inclusion in the Medicaid Long Term Cost Report forms.

~~D~~E. 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.

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~~,~~ as the calendar day the resident left the facility. A new leave of absence for hospitalization does not begin until ~~is broken only if~~ the resident returns to the facility for a period of twenty-four (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 the hospital ~~leave~~ when the resident has not been hospitalized for more than fifteen (15) consecutive 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) consecutive 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 Mississippi Division of Medicaid ~~provider manual~~Provider Billing Handbook and Administrative Code.

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 ~~applicable~~ Mississippi Division of Medicaid Provider Billing Handbook and~~provider manual~~ Administrative Code.

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. Refer to Roster Reports below for an exception to the close of the quarter.

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%) or greater 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 and bed hold 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.

~~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.~~

An ADL score is calculated for all assessments. The ADL score determines which group the assessment is under for its specific category. The only exception is the category of Extensive Services.

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.

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).

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; respiratory therapists; feeding assistants; contract RN's, contract LPN's, and contract nurse aides; contract respiratory therapists; contract feeding assistants; ~~,~~ medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

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, 2014~~3~~ through September 30, 2014~~3~~. 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

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

3-7 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 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: 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.

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

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.

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

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%.

Direct Care Costs-Expenses incurred by nursing facilities for the hands on care of the residents. These costs include salaries and fringe benefits for Rregistered Nnurses (RN's), (excluding the Director of Nursing, the Assistant Director of Nursing and the Resident Assessment Instrument (RAI) Coordinator; Llicensed Ppractical Nnurses (LPN's); nurse aides; feeding assistants; contract RN's, LPN's, Respiratory Therapist (RTs) 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.

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

For facilities with costs allocated from hospitals, home offices and related management companies the listed information is required for all entities. All cost reports must be filed in electronic format, with the following:

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

2. Grouping schedule showing the general ledger accounts grouped together and reported on the various lines of the cost report.

3. Depreciation Schedule(s). If the facility has different book and Medicaid depreciation schedules, copies of both depreciation schedules must be submitted.

4. Any work papers used to compute the reclassifications and adjustments made in the cost report(s);

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

6. Form 2 with an original signature on the Certification by Officer or Administrator of Provider. Scanned signatures are acceptable.
7. 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

are adopted 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 the Section II; Form 2 with original signature; and all forms that are being amended along with work papers for any revised reclassifications and/or adjustments. 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 review 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.

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. All desk reviews may be amended multiple times.
5. Desk reviews amended after the annual base rate is determined will be used only to adjust the individual provider's rates.
6. Desk reviews may not be the final determination of allowable costs used in the calculation of the provider's rate. All cost reports have the potential to be audited.

J. Audits of Financial Records

The Division of Medicaid will conduct 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 amended cost reports must be maintained for a period of three (3) years after the submission date of the amended cost report. 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 audit, 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. Information requested during an audit that is submitted after the provider's receipt of the Medicaid adjustment report will not be accepted. Providers will not be allowed to submit this information at a later date, 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.

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.

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. Accounting fees resulting from suits against federal and or state agencies administering the Medicaid program are not allowable costs and should not be claimed until all appeal remedies have been exhausted and the provider has prevailed in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these accou nting fees in the current cost report period open at that time.

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

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, expenses and costs incurred by nursing facilities shall be allowable, in the period incurred, if said costs are reasonable, necessary and patient-related. These legal fees, expenses and costs shall be documented in the provider’s file, and shall be clearly identifiable, including identification by case number and title, if possible. Failure to clearly identify these costs shall result in disallowance.

Legal fees resulting from suits against federal and/or state agencies administering the Medicaid program are not allowable costs and should not be claimed until all appeal remedies have been exhausted and the provider has prevailed in their appeal or litigation. Once the provider has prevailed and all appeal remedies have been exhausted, the provider may claim these legal fees in the current cost report period open at that time.

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.

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' and Officer’s Salaries. A reasonable allowance of compensation for services of owners and officers 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 or officer 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 or officer 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 or officers, 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 or officer 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 or officers average time worked which is less than forty hours per week. Owners and officers are allowed to receive compensation from more than one facility. Total hours

worked per week at all owned facilities cannot 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.

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 are allowable. Physical, Occupational and Speech Language Pathology therapy expenses will be included in the per diem rate for NFSD, PRTF and ICF/IID providers. Physical, Occupational and Speech Language Pathology therapy expenses for Small Nursing Facilities and Large Nursing Facilities will be reimbursed on a fee for service basis. Respiratory therapy expenses will be included in the per diem rate for all long-term care facilities.

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 monthly nursing facility, ICF/IID and PRTF bed assessments based on bed occupancy, 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.

22. Training Costs. Training costs, other than nurse aide training, are an allowable cost where the fees paid are (a) to maintain current license/certifications, (b) or directly applicable to your current position, and therefore related to patient care, or (c) for training on software updates. The costs are allowable in the cost report period incurred.

23. Educational costs to attain a college or technical degree resulting in the attainment of an increase in license level (e.g. CNA receiving an LPN, or RN degree or certification) – Costs of education of employees at accredited and technical institutions to acquire an undergraduate or graduate degree are allowable in accordance with the Provider Reimbursement Manual (PRM) 15-1 section 416.3 as modified by the following;

    The costs should not be claimed until the cost report period after the employee has attained their degree/certification. The costs should amortized over a similar number of periods for which tuition was paid or the continued employment agreement period (between the employee and the facility) whichever is longer. i.e. If 4 semesters of tuition were paid, then the expense should be spread over 2 years of a cost report period.

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.

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. Other Medicaid assessments

   a) Any portion of Medicaid Hospital assessments and IGTs, will be considered non-allowable costs on the cost report filed by each long-term care facility.

   b) Medicaid Assessments other than the monthly Medicaid LTC bed assessments based on occupancy, will be considered non-allowable costs on the cost report filed by each long-term care facility.

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, late payment fees 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.

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. Hospital Based Costs Allocation

1. For costs allocated from hospitals, the costs must be reasonable and necessary in the provision of patient care at the long-term care facility (LTC) providers. All cost allocation determinations must be in accordance with Chapters 21, 22 and 23 of PRM Publication 15-1.
2. Allocation of these costs must be in a manner that is auditable and that is supported by documentation that verifies the allocation of expense is applicable to the LTC facility for which services were rendered.
3. For LTC facilities that are not contiguous to the hospital, square footage or number of personnel is not an acceptable allocation statistic. Documented provision of service must be maintained related to the allocation of any cost center other than Administrative and General (A&G), which should be allocated on the accumulated cost basis. This documentation includes, but is not limited to, time or assignment schedules documenting the provision of service to the affected LTC facility.
4. As part of the allocation of the A&G cost center, only costs of those areas, included in the A&G center, that provided service to the attached LTC facility should be allocated to them.
5. Hospital providers are not mandated to componentize their A&G or other cost centers; but, should the hospital provider choose not to do so, any expenses allocated to the LTC facility contrary to the instructions in items 1-4 above should be calculated and removed before inclusion in the Medicaid Long Term Cost Report forms.

E. 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.

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 the first day of leave as the calendar day the resident left the facility. A new leave of absence for hospitalization does not begin until the resident returns to the facility for a period of twenty-four (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 the hospital when the resident has not been hospitalized for more than fifteen (15) consecutive 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) consecutive 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 Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code.

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 Mississippi Division of Medicaid Provider Billing Handbook and Administrative Code.

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. Refer to Roster Reports below for an exception to the close of the quarter.

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 twenty-five percent (25%) or greater 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 and bed hold 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.

An ADL score is calculated for all assessments. The ADL score determines which group the assessment is under for its specific category. The only exception is the category of Extensive Services.

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.

In an index maximized classification system, assessments are sorted from those having the highest acuity/resource utilization to those with the least acuity/resource utilization. Once the criteria for placement in one of the seven major categories is met, the 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).

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; respiratory therapists; feeding assistants; contract RN's, contract LPN's, and contract nurse aides; contract respiratory therapists; contract feeding assistants; medical supplies and other direct care supplies; medical waste disposal; and allowable drugs.

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, 2014~~3~~ through September 30, 2014. 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

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

3-7 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 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: 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.

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

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.

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

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%.

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, Respiratory Therapist (RTs) 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.