Table of Contents

State/Territory Name: KS

State Plan Amendment (SPA) #: 16-0014

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

MAY 24 2017

Michael Randol, Director
Kansas Department of Health and Environment
Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

RE: Kansas State Plan Amendment TN: 16-014

Dear Mr. Randol:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 16-014. This amendment reduces base Nursing Facility payment rates by 4.0%. This SPA also updates charts and exhibits within the State plan that demonstrate the revised factors and limits applicable to the rate period beginning with SFY 2016. The SPA also updates State Administrative Regulations that are included as attachments to the Plan.

As part of our review of the pending SPA, we requested the State to demonstrate that the payment rate decrease would not restrict access to services for the fee-for-service population in the Kansas Medicaid program. The State provided data confirming that 97% of Medicaid beneficiaries in Kansas receive care through a managed care arrangement and that the 3% remaining in the fee-for-service system includes individuals that receive limited specialty services or services in periods of presumptive or retro-active eligibility. Based on this information, the state concluded that access will not be affected by the rate reductions under SPA 16-014. The State must continue to monitor access to care for the fee-for-service population and promptly notify us if access to care appears to be lessening.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment 16-014 is approved effective July 1, 2016. We are enclosing the CMS-179 and the amended plan page.

If you have any questions, please call Tim Weidler at (816) 426-6429.

Sincerely,

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: KS 16-014

2. STATE: Kansas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.201, 42 CFR 442.10

7. FEDERAL BUDGET IMPACT
a. FFY 2016 ($117,241)
b. FFY 2017 ($471,058)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Attachment 4.19D, Part 1, Exhibit A-5, Page 1-6, 7-25, 27
Attachment 4.19D, Part 1, Exhibit A-6, Page 1-14
Attachment 4.19D, Part 1, Exhibit A-14, Page 1-5
Attachment 4.19D, Part 1, Exhibit A-19, Page 1-2 (New)
Attachment 4.19D, Part 1, List of Contents, Page 1
Attachment 4.19D, Part 1, Subpart C, Exhibit C-1, Page 1-19, 17a
Attachment 4.19D, Part 1, Subpart C, Exhibit C-2, Page 1,2,3,3a,3b,3c,5
Attachment 4.19D, Part 1, Subpart C, Exhibit C-3, Page 1,2,3a
Attachment 4.19D, Part 1, Subpart C, Exhibit C-4, Page 1,2
Attachment 4.19D, Part 1, Subpart C, Exhibit C-5, Page 1,2,3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19D, Part 1, Exhibit A-5, Page 1-6, 7-25, 27
Attachment 4.19D, Part 1, Exhibit A-6, Page 1-14
Attachment 4.19D, Part 1, Exhibit A-14, Page 1-5
Attachment 4.19D, Part 1, List of Contents, Page 1
Attachment 4.19D, Part 1, Subpart C, Exhibit C-1, Page 1-19, 17a
Attachment 4.29D, Part 1, Subpart C, Exhibit C-2, Page 1,2,3,3a,3b,3c,5
Attachment 4.19D, Part 1, Subpart C, Exhibit C-3, Page 1,2,3a
Attachment 4.19D, Part 1, Subpart C, Exhibit C-4, Page 1,2
Attachment 4.19D, Part 1, Subpart C, Exhibit C-5, Page 1,2,3

10. SUBJECT OF AMENDMENT
Nursing Facility Annual Rate Increase

11. GOVERNOR'S REVIEW *(Check One)*
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Michal Randol is the Governor's Designee

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
for Michael Randol

14. TITLE
Director, Division of Health Care Finance

15. DATE SUBMITTED
September 30, 2016

16. RETURN TO
Michael Randol, Director
KDHE, Division of Health Care Finance
Landon State Office Building
900 SW Jackson, Room 900-N
Topeka, KS 66612-1220

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED MAY 24 2017

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME Kristin Fan

22. TITLE Director, FMG

23. REMARKS

FORM CMS-179 (07/92

Instructions on Back

129-10-18. Per diem rates of reimbursement. (a) Per diem rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information.

(C) For each provider currently in new enrollment, reenrollment, or change of ownership status, the base year shall be determined in accordance with subsections (c), (d), and (e), respectively.

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the agency.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care.

(B) The property component shall consist of the real and personal property fee as specified in K.A.R. 129-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's base-year costs adjusted for case mix.

(i) A facility-specific, direct health care cost center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an annual per diem rate to become effective July 1 and, if there are any changes in the facility's average medicaid case mix index, an adjusted per diem rate to become effective January 1.

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6)(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in the direct health care cost center. The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) For homes with more than 60 beds, the number of resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period, as specified in K.A.R. 129-10-17, shall have the number of resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the number

of resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period, as specified in K.A.R. 129-10-17, used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 129-10-19.

(b) Per diem rate limitations based on comparable service private-pay charges.

(1) Rates of reimbursement shall not be limited by private-pay charges.

(2) The agency shall maintain a registry of private-pay per diem rates submitted by providers.

(A) Each provider shall notify the agency of any change in the private-pay rate and the effective date of that change so that the registry can be updated.

(i) Private-pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private-pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private-pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private-pay rate in the registry shall be the later of the effective date of the private-pay rate or the first day of the following month in which complete documentation of the private-pay rate is received by the agency.

(i) If the effective date of the private-pay rate is other than the first day of the month, the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the effective date of the private-pay rate shall be the date on which certification is issued.

(3) The average private-pay rate for comparable services shall be included in the

registry. The average private-pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private-pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private-pay residents in all rooms. The result, or quotient, is the weighted average private-pay rate for room differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average private-pay rate if there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private-pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private-pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private-pay residents in all levels of care. The result, or quotient, is the weighted average private-pay

rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private-pay rate in the registry until the complete documentation is received.

(C) Extra charges to private-pay residents for items and services may be included in the weighted average private-pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private-pay rate in the registry until the complete documentation is received.

(4) The weighted average private-pay rate shall be based on what the provider receives from the resident. If the private-pay charges are consistently higher than what the provider receives from the residents for services, then the average private-pay rate for comparable services shall be based on what is actually received from the residents. The weighted average private-pay rate shall be reduced by the amount of any discount

received by the residents.

(5) The private-pay rate for medicare skilled beds shall not be included in the computation of the average private-pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private-pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average medicaid case mix index is greater than the average private-pay case mix index, the Kansas medical assistance program rate shall be the lower of the private-pay rate adjusted to reflect the medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average medicaid case mix index is less than or equal to the average private-pay case mix index, the Kansas medical assistance program rate shall be the average private-pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private-pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the

date upon which complete private-pay rate documentation is received or the effective date of a new private-pay rate.

(c) Per diem rate for new construction or a new facility to the program.

(1) The per diem rate for any newly constructed nursing facility or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

(2) The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the base-year period.

(3) The provider shall remain in new enrollment status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

(5) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base-year data is not

available, data for the most recent calendar year available preceding the base-year period shall be adjusted to the base-year period and used to determine the rate. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) Beginning with the first day of the 25th month of operation, the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider. The data shall be adjusted to the base-year period.

(3) The provider shall remain in change-of-provider status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change-of-provider status.

(e) Determination of the per diem rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report if the provider has not actively participated in the

program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the base-year cost report filed with the agency or the most recent cost report filed preceding the base year, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), the cost data shall be adjusted to the base-year period.

(3) The provider shall remain under reenrollment status until the base year is reestablished. During this time, the cost data used to determine the initial rates shall be used to determine all subsequent rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the cost data for providers in reenrollment status.

(5) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or that provider's corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements. In all cases, settlements shall be recouped within 12 months of the implementation of the corrected rates, or interest may be assessed.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider

wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report, as specified in K.A.R. 129-10-17, for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The per diem rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Each out-of-state provider shall obtain prior authorization by the agency.

(h) Reserve days. Reserve days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in writing for prior approval. Each request shall include

the following:

(A) Sections A, I, and O in the nursing home comprehensive "minimum data set" ("MDS") of the centers for medicare and medicaid services (CMS);

(B) a current client assessment, referral, and evaluation (CARE) plan for the resident;

(C) a physician's order for ventilator use, including the frequency of ventilator use and a diagnosis that requires use of a ventilator; and

(D) a treatment administration record or respiratory therapy note showing the number of minutes used for the ventilator per shift.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator-dependent:

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the

agency for the ventilator-dependent resident.

(4) No additional amount above that figured at the Kansas medical assistance program daily rate shall be allowed until the service has been authorized by the agency.

(5) The criteria shall be reviewed quarterly to determine if the resident is ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas medical assistance program daily rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report.

(j) Rate modification; secretary's discretion.

(1) Any of the requirements of this regulation may be waived by the secretary and a nursing facility's or nursing facility for mental health's per diem rate of reimbursement may be modified by the secretary if the secretary determines that both of the following conditions are met:

(A) Exceptional circumstances place residents of nursing facilities and nursing facilities for mental health in jeopardy of losing the availability of, or access to, "routine services and supplies," "ancillary services and other medically necessary services,"

"specialized mental health rehabilitation services," or "specialized services," as defined in K.A.R. 30-10-1a.

(B) The jeopardy can likely be avoided or reduced by modifying the per diem rate of reimbursement for a nursing facility or nursing facility for mental health.

(2) If the secretary exercises discretion pursuant to this subsection, the increase in the per diem rate of reimbursement shall not exceed the state average rate for reimbursement. (Authorized by K.S.A 2015 Supp. 65-1,254 and 75-7403; implementing K.S.A. 2015 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008; amended; Feb 5, 2016.)

State of Kansas
Department for Aging and Disability Services

MS-2004
Rev. 08/16

NURSING FACILITY FINANCIAL AND STATISTICAL REPORT

SEND TO: KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES New England Building 503 S. Kansas Avenue TOPEKA, KANSAS 66603-3404	AGENCY USE ONLY			
	(1,2)		RETRO ADJUSTMENT	
	(3,4)		FULL	PARTIAL
	(5,6)			

INSTRUCTIONS AND REGULATIONS ARE AN INTEGRAL PART OF THIS REPORT. YOU MUST READ THEM BEFORE COMPLETING.

SRS PROVIDER ID NUMBER (NEED 10 DIGITS)	EDS PROVIDER NUMBER (NEED 10 DIGITS)	11. EMPLOYERS' FEDERAL ID NUMBER
0	0	0

12. PROVIDER NAME (The person or business organization responsible for meeting requirements, providing services and receiving payments.)	13. FACILITY NAME
0	0

14. & 15. FACILITY ADDRESS (STREET, CITY, STATE, ZIP)

0 0 0 0

16. ADMINISTRATOR'S NAME	17a. PHONE NUMBER	18. EMAIL ADDRESS	
	0	19. REPORT PERIOD	20. FISCAL YEAR END
	17b. FAX NUMBER		
0	0	01/00/00 TO 01/00/00	01/00/00

CHECK ONLY ONE

21. ____ CALENDAR YEAR HISTORICAL
22. ____ PROJECTED (NEW PROVIDER/FACILITY)
23. ____ FIRST HISTORICAL NON-CALENDAR YEAR (R/Y SAME PERIOD AS PROJECTED)

CHECK ONLY ONE

26. ____ SOLE PROPRIETORSHIP
27. ____ PARTNERSHIP
28. ____ CORP - PROFIT
29. ____ CORP. - NON PROFIT
30. ____ CITY OWNED
31. ____ COUNTY OWNED
32. ____ OTHER - GOVERNMENT OWNED
33. ____ OTHER (SPECIFY)

NURSING FACILITY BEDS	BED INCREASE OR DEC.	DATE OF CHANGE	BED COUNT	BED DAYS AT THIS BED COUNT
43. NURSING FACILITY OR NF-MENTAL HEALTH BEDS AT THE BEG. OF THE PERIOD			0	0
	43a. 0	0	0	0
	43b. 0	0	0	0
	43c. 0	0	0	0
	43d. 0	0	0	0
45. TOTAL NF OR NF-MH LICENSED BEDS AT THE END OF THE PERIOD				0
46. TOTAL BED DAYS AVAILABLE (TOTAL OF BED DAYS AT THIS COUNT COLUMN FROM LINES 43 THROUGH 43d)				0
48. TOTAL NURSING FACILITY /NFMH RESIDENT DAYS (ALL RESIDENTS FROM AU-3902 DISKETTE) (4)				0
48a. TOTAL MEDICAID DAYS (5)				0
48b. TOTAL MEDICARE DAYS				0

OTHER FACILITY BEDS	BEGINNING OF PERIOD	BED INCREASE OR DEC.	DATE OF CHANGE	END OF PERIOD
49. ASSISTED LIVING/RES. CARE	0	0	01/00/00	0
50. UNLICENSED BEDS	0	0	01/00/00	0
51. OTHER RESIDENTIAL DAYS WITH SHARED NURSING FACILITY COSTS (ALL RESIDENTS FROM AU-3903 DISKETTE)				0

52. DOES THE FACILITY HAVE MEDICARE CERTIFIED BEDS? ☐ YES ☐ NO IF YES, COMPLETE 48b

53. IS THIS FACILITY (please check one): ☐ HOSPITAL BASED LTCU ☐ FREE-STANDING NF

This form Supersedes Form MS-2004, Rev. 08/16

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Under the Medicaid program, the State of Kansas pays nursing facilities (NF), nursing facilities for mental health (NFMH), and hospital long-term care units (hereafter collectively referred to as nursing facilities) a daily rate for care provided to residents who are eligible for Medicaid benefits. The narrative explanation of the nursing facility reimbursement formula is divided into twelve sections. The sections are: Cost Reports, Rate Determination, Quarterly Case Mix Index Calculation, Resident Days, Inflation Factors, Upper Payment Limits, Quarterly Case Mix Rate Adjustment, Real and Personal Property Fee, Incentive Factors, Rate Effective Date, and Retroactive Rate Adjustments and Budget Adjustments.

1) Cost Reports

The Nursing Facility Financial and Statistical Report (MS2004) is the uniform cost report. It is included in Kansas Administrative Regulation (K.A.R.) 129-10-17. It organizes the commonly incurred business expenses of providers into three reimbursable cost centers (operating, indirect health care, and direct health care). Ownership costs (i.e., mortgage interest, depreciation, lease, and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers' accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports:

All providers that have operated a facility for 12 or more months on December 31 shall file a calendar year cost report. The requirements for filing the calendar year cost report are found in K.A.R. 129-10-17.

When a non-arm's length or related party change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator for the months during the calendar year in which the new operator was not involved in running the facility. The

cost report information from the old and new operators shall be combined to prepare a 12-month calendar year end cost report.

Projected Cost Reports:

The filing of projected cost reports are limited to: 1) newly constructed facilities; 2) existing facilities new to the Medicaid program; or 3) a provider re-entering the Medicaid program that has not actively participated or billed services for 24 months or more. The requirements are found in K.A.R. 129-10-17.

2) Rate Determination

Rates for Existing Nursing Facilities

Medicaid rates for Kansas NFs are determined using a prospective, facility-specific rate-setting system. The rate is determined from the base cost data submitted by the provider. The current base cost data is the combined calendar year cost data from each available report submitted by the current provider during 2013, 2014, and 2015.

If the current provider has not submitted a calendar year report during the base cost period, the cost data submitted by the previous provider for that same period will be used as the base cost data. Once the provider completes their first 24 months in the program, their first calendar year cost report will become the provider's base cost data.

The allowable expenses are divided into three cost centers. The cost centers are Operating, Indirect Health Care and Direct Health Care. They are defined in K.A.R. 129-10-18.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by resident days. Before determining the per diem cost, each year's cost data is adjusted from the midpoint of that year to June 30, 2016. The resident days and inflation factors used in the rate determination will be explained in greater detail in the following sections.

The inflated allowable historic per diem cost for each cost center is then compared to the cost center upper payment limit. The allowable per diem rate is the lesser of the inflated allowable historic per diem cost in each cost center or the cost center upper payment limit. Each cost center has a separate upper payment limit. If each cost center

upper payment limit is exceeded, the allowable per diem rate is the sum of the three cost center upper payment limits. There is also a separate upper payment limit for owner, related party, administrator, and co-administrator compensation. The upper payment limits will be explained in more detail in a separate section.

The case mix of the residents adjusts the Direct Health Care cost center. The reasoning behind a case mix payment system is that the characteristics of the residents in a facility should be considered in determining the payment rate. The idea is that certain resident characteristics can be used to predict future costs to care for residents with those same characteristics. For these reasons, it is desirable to use the case mix classification for each facility in adjusting provider rates.

There are add-ons to the allowable per diem rate. The add-ons consist of the incentive factor, the real and personal property fee, and per diem pass-throughs to cover costs not included in the cost report data. The incentive factor and real and personal property fee are explained in separate sections of this exhibit. Pass-throughs are explained in separate subparts of Attachment 4.19D of the State Plan. The add-ons plus the allowable per diem rate equal the total per diem rate.

Rates for New Construction and New Facilities (New Enrollment Status)

The per diem rate for newly constructed nursing facilities, or new facilities to the Kansas Medical Assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to June 30, 2016. This adjustment will be based on the IHS Global Insight, National Skilled Nursing Facility Market Basket Without Capital Index (IHS Index). The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to June 30, 2016. The provider shall remain in new enrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

Rates for Facilities Recognized as a Change of Provider (Change of Provider Status)

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The payment rate for the first 24 months of operation shall be based on the base cost data of the previous owner or provider. This base cost data shall include data from each calendar year cost report that was filed by the previous provider from 2013 to 2015. If base cost data is not available the most recent calendar year data for the previous provider shall be used. Beginning with the first day of the 25th month of operation the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider.

All data used to set rates for facilities recognized as a change-of-provider shall be adjusted to June 30, 2016. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to June 30, 2016. The provider shall remain in change-of-provider status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change of provider status.

Rates for Facilities Re-entering the Program (Reenrollment Status)

The per diem rate for each provider reentering the Medicaid program shall be determined from a projected cost report if the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more. The per diem rate for all other providers reentering the program shall be determined from the base cost data filed with the agency or the most recent cost report filed preceding the base cost data period.

All cost data used to set rates for facilities reentering the program shall be adjusted to June 30, 2016. This adjustment will be based on the IHS Index. The IHS indices listed in the latest available quarterly publication will be used to adjust the reported cost data from the midpoint of the cost report period to June 30, 2016. The provider shall remain in reenrollment status until the base data is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider. Any additional factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in reenrollment status.

3) Quarterly Case Mix Index Calculation

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Providers are required to submit to the agency the uniform assessment instrument, which is the Minimum Data Set (MDS), for each resident in the facility. The MDS assessments are maintained in a computer database.

The Resource Utilization Groups-III (RUG-III) Version 5.12b, 34 group, index maximizer model is used as the resident classification system to determine all case- mix indices, using data from the MDS submitted by each facility. Standard Version 5.12b case mix indices developed by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) shall be the basis for calculating facility average case mix indices to be used to adjust the Direct Health Care costs in the determination of upper payment limits and rate calculation. Resident assessments that cannot be classified will be assigned the lowest CMI for the State.

Each resident in the facility on the first day of each calendar quarter with a completed and submitted assessment shall be assigned a RUG-III 34 group calculated on the resident's most current assessment available on the first day of each calendar quarter. This RUG-III group shall be translated to the appropriate CMI. From the individual resident case mix indices, three average case mix indices for each Medicaid nursing facility shall be determined four times per year based on the assessment information available on the first day of each calendar quarter.

The facility-wide average CMI is the simple average, carried to four decimal places, of all resident case mix indices. The Medicaid-average CMI is the simple average, carried to four decimal places, of all indices for residents, including those receiving hospice services, where Medicaid is known to be a per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. The private-pay/other average CMI is the simple average, carried to four decimal places, of all indices for residents where neither Medicaid nor Medicare were known to be the per diem payer source on the first day of the calendar quarter or at any time during the preceding quarter. Case mix indices for ventilator-dependent residents for whom additional reimbursement has been determined shall be excluded from the average CMI calculations.

Rates will be adjusted for case mix twice annually using case mix data from the two quarters preceding the rate effective date. The case mix averages used for the rate adjustments will be the simple average of the case mix averages for each quarter. The resident listing cut-off for calculating the average CMIs for each quarter will be the first day of the quarter. The following are the dates for the resident listings and the rate periods in which the average Medicaid CMIs will be used in the semi-annual rate-setting process.

cost report and the historic cost report covering the projected cost report period are based on the actual resident days for the period.

The second exception is for the first cost report filed by a new provider who assumes the rate of the previous provider. If the 85% minimum occupancy rule was applied to the previous provider's rate, it is also applied when the rate is assigned to the new provider. However, when the new provider files a historic cost report for any part of the first 12 months of operation, the rate determined from the cost report will be based on actual days and not be subject to the 85% minimum occupancy rule for the months in the first year of operation. The 85% minimum occupancy rule is then reapplied to the rate when the new provider reports resident days and costs for the 13th month of operation and after.

5) Inflation Factors

Inflation will be applied to the allowable reported costs from the calendar year cost report(s) used to determine the base cost data from the midpoint of each cost report period to June 30, 2016. The inflation will be based on the IHS Global Insight, CMS Nursing Home without Capital Market Basket index.

The IHS Global Insight, CMS Nursing Home without Capital Market Basket Indices listed in the latest available quarterly publication will be used to determine the inflation tables for the payment schedules processed during the payment rate period. This may require the use of forecasted factors in the inflation table. The inflation tables will not be revised until the next payment rate period.

The inflation factor will not be applied to the following costs:

1) Owner/Related Party Compensation
2) Interest Expense
3) Real and Personal Property Taxes

The inflation factor for the real and personal property fees will be based on the IHS index.

6) Upper Payment Limits

There are three types of upper payment limits that will be described. One is the owner/related party/administrator/co-administrator limit. The second is the real and personal property fee limit. The last type of limit is an upper payment limit for each cost

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

center. The upper payment limits are in effect during the payment rate period unless otherwise specified by a State Plan amendment.

Owner/Related Party/Administrator/Co-Administrator Limits:

Since salaries and other compensation of owners are not subject to the usual market constraints, specific limits are placed on the amounts reported. First, amounts paid to non-working owners and directors are not an allowable cost. Second, owners and related parties who perform resident related services are limited to a salary chart based on the Kansas Civil Service classifications and wages for comparable positions. Owners and related parties who provide resident related services on less than a full time basis have their compensation limited by the percent of their total work time to a standard work week. A standard work week is defined as 40 hours. The owners and related parties must be professionally qualified to perform services which require licensure or certification.

The compensation paid to owners and related parties shall be allocated to the appropriate cost center for the type of service performed. Each cost center has an expense line for owner/related party compensation. There is also a cost report schedule titled, "Statement of Owners and Related Parties." This schedule requires information concerning the percent of ownership (if over five percent), the time spent in the function, the compensation, and a description of the work performed for each owner and/or related party. Any salaries reported in excess of the Kansas Civil Service based salary chart are transferred to the Operating cost center where the excess is subject to the Owner/Related Party/Administrator/Co-Administrator per diem compensation limit.

The Schedule C is an array of non-owner administrator and co-administrator salaries. The schedule includes the calendar year 2015 historic cost reports in the database from all active nursing facility providers. The salary information in the array is not adjusted for inflation. The per diem data is calculated using an 85% minimum occupancy level for those providers in operation for more than 12 months with more than 60 beds. The Schedule C for the owner/related party/administrator/co-administrator per diem compensation limit is the first schedule run during the rate setting.

The Schedule C is used to set the per diem limitation for all non-owner administrator and co-administrator salaries and owner/related party compensation in excess of the civil service based salary limitation schedule. The per diem limit for a 50-bed or larger home is set at the 90th percentile on all salaries reported for non-owner

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

administrators and co-administrators. A limitation table is then established for facilities with less than 50 beds. This table begins with a reasonable salary per diem for an administrator of a 15-bed or less facility. The per diem limit for a 15-bed or less facility is inflated based on the State of Kansas annual cost of living allowance for classified employees for the rate period. A linear relationship is then established between the compensation of the administrator of the 15-bed facility and the compensation of the administrator of a 50-bed facility. The linear relationship determines the per diem limit for the facilities between 15 and 50 beds.

The per diem limits apply to the non-owner administrators and co-administrators and the compensation paid to owners and related parties who perform an administrative function or consultant type of service. The per diem limit also applies to the salaries in excess of the civil service based salary chart in other cost centers that are transferred to the operating cost center.

Real and Personal Property Fee Limit

The property component of the reimbursement methodology consists of the real and personal property fee that is explained in more detail in a later section. The upper payment limit will be 105% of the median determined from a total resident day-weighted array of the property fees in effect April 1, 2016.

Cost Center Upper Payment Limits

The Schedule B computer run is an array of all per diem costs for each of the three cost centers-Operating, Indirect Health Care, and Direct Health Care. The schedule includes a per diem determined from the base cost data from all active nursing facility providers. Projected cost reports are excluded when calculating the limit.

The per diem expenses for the Operating cost center and the Indirect Health Care cost center less food and utilities are subject to the 85% minimum occupancy for facilities over 60 beds. All previous desk review and field audit adjustments are considered in the per diem expense calculations. The costs are adjusted by the owner/related party/administrator/co-administrator limit.

Prior to the Schedule B arrays, the cost data on certain expense lines is adjusted from the midpoint of the cost report period to June 30, 2016. This will bring the costs reported by the providers to a common point in time for comparisons. The inflation will be based

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

on the IHS Global Insight, CMS Nursing Home without Capital Market Basket Index.

Certain costs are exempt from the inflation application when setting the upper payment limits. They include owner/related party compensation, interest expense, and real and personal property taxes.

The final results of the Schedule B run are the median compilations. These compilations are needed for setting the upper payment limit for each cost center. The median for each cost center is weighted based on total resident days. The upper payment limits will be set using the following:

Operating	110% of the median
Indirect Health Care	115% of the median
Direct Health Care	130% of the median

Direct Health Care Cost Center Limit:

The Kansas reimbursement methodology has a component for a case mix payment adjustment. The Direct Health Care cost center rate component and upper payment limit are adjusted by the facility average CMI.

For the purpose of setting the upper payment limit in the Direct Health Care cost center, the facility cost report period CMI and the statewide average CMI will be calculated. The facility cost report period CMI is the resident day-weighted average of the quarterly facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the financial and statistical reporting period. For example, a 01/01/20XX-12/31/20XX financial and statistical reporting period would use the facility-wide average case mix indices for quarters beginning 04/01/XX, 07/01/XX, 10/01/XX and 01/01/XY. The statewide average CMI is the resident day-weighted average, carried to four decimal places, of the facility cost report period case mix indices for all Medicaid facilities.

The statewide average CMI and facility cost report period CMI are used to set the upper payment limit for the Direct Health Care cost center. The limit is based on all facilities with a historic cost report in the database. There are three steps in establishing the base upper payment limit.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The first step is to normalize each facility's inflated Direct Health Care costs to the statewide average CMI. This is done by dividing the facility's cost report period CMI by the statewide average CMI for the cost report year, then multiplying this answer by the facility's inflated costs. This step is repeated for each cost report year for which data is included in the base cost data.

The second step is to determine per diem costs and array them to determine the median. The per diem cost is determined by dividing the total of each provider's base direct health care costs by the total days provided during the base cost data period. The median is located using a day-weighted methodology. That is, the median cost is the per diem cost for the facility in the array at which point the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all providers. The facility with the median resident day in the array sets the median inflated direct health care cost. For example, if there are eight million resident days, the facility in the array with the 4 millionth day would set the median.

The final step in calculating the base Direct Health Care upper payment limit is to apply the percentage factor to the median cost. For example, if the median cost is $60 and the upper payment limit is based on 130% of the median, then the upper payment limit for the statewide average CMI would be $78 (**D**=130% x $60).

7) Quarterly Case Mix Rate Adjustment

The allowance for the Direct Health Care cost component will be based on the average Medicaid CMI in the facility. The first step in calculating the allowance is to determine the Allowable Direct Health Care Per Diem Cost. This is the lesser of the facility's per diem cost from the base cost data period or the Direct Health Care upper payment limit. Because the direct health care costs were previously adjusted for the statewide average CMI, the Allowable Direct Health Care Per Diem Cost corresponds to the statewide average CMI.

The next step is to determine the Medicaid acuity adjusted allowable Direct Health Care cost. The facility's Medicaid CMI is determined by averaging the facility average Medicaid CMI from the two quarters preceding the rate effective data. The Medicaid CMI is then divided by the statewide average CMI for the cost data period. Finally, this result, is then multiplied by the Allowable Direct Health Care per diem cost. The result is referred to as the Medicaid Acuity Adjustment.

The Medicaid Acuity Adjustment is calculated semi-annually to account for changes in the Medicaid CMI. To illustrate this calculation take the following situation: The

facility's direct health care per diem cost is $60.00, the Direct Health Care per diem limit is $78.00, and these are both tied to a statewide average CMI of 1.000, and the facility's current Medicaid CMI is 0.9000. Since the per diem costs are less than the limit the Allowable Direct Heath Care Cost is $60.00, and this is matched with the statewide average CMI of 1.0000. To calculate the Medicaid Acuity Adjustment, first divide the Medicaid CMI by the statewide average CMI, then multiply the result by the Allowable Direct Health Care Cost. In this case that would result in $54.00 (0.9000/1.0000 x $60.00). Because the facility's current Medicaid CMI is less than the statewide average CMI the Medicaid Acuity Adjustment moves the direct health care per diem down proportionally. In contrast, if the Medicaid CMI for the next semi-annual adjustment rose to 1.1000, the Medicaid Acuity Adjustment would be $66.00 (1.1000/1.0000 x $60.00). Again the Medicaid Acuity Adjustment changes the Allowable Direct Health Care Per Diem Cost to match the current Medicaid CMI.

8) Real and Personal Property Fee

The property component of the reimbursement methodology consists of the real and personal property fee (property fee). The property fee is paid in lieu of an allowable cost of mortgage interest, depreciation, lease expense and/or amortization of leasehold improvements. The fee is facility specific and does not change as a result of a change of ownership, change in lease, or with re-enrollment in the Medicaid program. The original property fee was comprised of two components, a property allowance and a property value factor. The differentiation of the fee into these components was eliminated effective July 1, 2002. At that time each facility's fee was re-established based on the sum of the property allowance and value factor. The providers receive the lower of the inflated property fee or the upper payment limit.

For providers re-enrolling in the Kansas Medical Assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the property fee shall be the sum of the last effective property allowance and the last effective value factor for that facility. The property fee will be inflated to 12/31/08 and then compared to the upper payment limit. The property fee will be the lower of the facility-specific inflated property fee or the upper payment limit.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Providers entering the Kansas Medical Assistance program for the first time, who are operating in a building for which a fee has not previously been established, shall have a property fee calculated from the ownership costs reported on the cost report. This fee shall include appropriate components for rent or lease expense, interest expense on real estate mortgage, amortization of leasehold improvements, and depreciation on buildings and equipment. The process for calculating the property fee for providers entering the Kansas Medical Assistance program for the first time is explained in greater detail in (K.A.R. 129-10-25).

There is a provision for changing the property fee. This is for a rebasing when capital expenditure thresholds are met ($25,000 for homes under 51 beds and $50,000 for homes over 50 beds). The original property fee remains constant but the additional factor for the rebasing is added. The property fee rebasing is explained in greater detail in (K.A.R. 129-10-25). The rebased property fee is subject to the upper payment limit.

9) Incentive Factors

An incentive factor will be awarded to both NF and NF-MH providers that meet certain outcome measures criteria. The criteria for NF and NF-MH providers will be determined separately based on arrays of outcome measures for each provider group.

Nursing Facility Quality and Efficiency Incentive Factor:

The Nursing Facility Incentive Factor is a per diem amount determined by six per diem add-ons providers can earn for various outcomes measures. Providers that maintain a case mix adjusted staffing ratio at or above the 75th percentile will earn a $2.25 per diem add-on. Providers that fall below the 75th percentile staffing ratio but improve their staffing ratio by 10% or more will earn a $0.20 per diem add-on. Providers that achieve a turnover rate at or below the 75th percentile will earn a $2.25 per diem add-on as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers that have a turnover rate greater than the 75th percentile but that reduce their turnover rate by 10% or more will receive a per diem add-on of $0.20 as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Finally, providers that have a Medicaid occupancy percentage of 60% or more will receive a $1.00 per diem add-on. The total of all the per diem add-ons a provider qualifies for will be their incentive factor.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The table below summarizes the incentive factor outcomes and per diem add-ons:

INCENTIVE OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 75th percentile (5.09), or	$2.25
CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
Staff turnover rate <= 75th percentile, 47 % or Staff turnover rate > 75th percentile but reduced >= 10% Contracted labor < 10% of total direct health care labor costs	$2.25 $0.20
Medicaid occupancy >= 60%	$1.00
Total Incentive Points Available	$5.90

Nursing Facility for Mental Health Quality and Efficiency Incentive Factor:

The Quality and Efficiency Incentive plan for Nursing Facilities for Mental Health (NFMH) will be established separately from NF. NFMH serve people who often do not need the NF level of care on a long term basis. There is a desire to provide incentive for NFMH to work cooperatively and in coordination with Community Mental Health Centers to facilitate the return of persons to the community.

The Quality and Efficiency Incentive Factor is a per diem add-on ranging from zero ($0.00) to seven dollars and fifty cents ($7.50). It is designed to encourage quality care, efficiency and cooperation with discharge planning. The incentive factor is determined by five outcome measures: case-mix adjusted nurse staffing ratio; operating expense; staff turnover rate; staff retention rate; and occupancy rate. Each provider is awarded points based on their outcomes measures and the total points for each provider determine the per diem incentive factor included in the provider's rate calculation.

Providers may earn up to two incentive points for their case mix adjusted nurse staffing ratio. They will receive two points if their case-mix adjusted staffing ratio equals or exceeds 3.56, which is 120% of the statewide NFMH median of 2.97. They will receive one point if the ratio is less than 120% of the NFMH median but greater than or equal to 3.27 which is 110% of the statewide NFMH median. Providers with staffing ratios below 110% of the NFMH median will receive no points for this incentive measure.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

NFMH providers may earn one point for low occupancy outcomes measures. If they have total occupancy less than 90% they will earn a point.

NFMH providers may earn one point for low operating expense outcomes measures. They will earn a point if their per diem operating expenses are below $18.60, or 90% of the statewide median of $20.67.

NFMH providers may earn up to two points for their turnover rate outcome measure. Providers with direct health care staff turnover equal to or below 39%, the 75th percentile statewide, will earn two points as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs. Providers with direct health care staff turnover greater than 39% but equal to or below 61%, the 50th percentile statewide, will earn one point as long as contracted labor costs do not exceed 10% of the provider's total direct health care labor costs.

Finally, NFMH providers may earn up to two points for their retention rate outcome measure. Providers with staff retention rates at or above 74%, the 75th percentile statewide will earn two points. Providers with staff retention rates below 74%, but at or above 62%, the 50th percentile statewide will earn one point.

The table below summarizes the incentive factor outcomes and points:

QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
CMI adjusted staffing ratio >= 120% (3.56) of NF-MH median (2.97), or CMI adjusted staffing ratio between 110% (3.27) and 120%	2, or 1
Total occupancy <= 90%	1
Operating expenses < $18.60, 90% of NF-MH median, $20.67	1
Staff turnover rate <= 75th percentile, 39% Staff turnover rate <= 50th percentile, 61% Contracted labor < 10% of total direct health care labor costs	2, or 1
Staff retention >= 75th percentile, 74% Staff retention >= 50th percentile, 62%	2, or 1
Total Incentive Points Available	8

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

The Schedule E is an array containing the incentive points awarded to each NFMH provider for each quality and efficiency incentive outcome. The total of these points will be used to determine each provider's incentive factor based on the following table.

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00

The Culture Change/Person-Centered Care Incentive Program

The Culture Change/Person-Centered Care Incentive Program (PEAK 2.0) includes six different incentive levels to recognize homes that are either pursuing culture change, have made major achievements in the pursuit of culture change, have met minimum competencies in person-centered care, have sustained person-centered care, or are mentoring others in person-centered care.

Each incentive level has a specific pay-for-performance incentive per diem attached to it that homes can earn by meeting defined outcomes. The first three levels (Level 0 – Level 2) are intended to encourage quality improvement for homes that have not yet met the minimum competency requirements for a person-centered care home. Homes can earn the Level 1 and Level 2 incentives simultaneously as they progress toward the minimum competency level.

Level 3 recognizes those homes that have attained a minimum level of core competency in person-centered care. Level 4 and Level 5 are reserved for those homes that have demonstrated sustained person-centered care for multiple years and have gone on to mentor other homes in their pursuit of person-centered care. The table below provides a brief overview of each of the levels.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Level & Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 0 The Foundation $0.50	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 must return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Level 5 Person-Centered Care Mentor Home $4.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

Survey and Certification Performance Adjustment

The survey and certification performance of each NF and NF-MH provider will be reviewed quarterly to determine each provider's eligibility for incentive factor payments. In order to qualify for an incentive factor payment a home must not have received any health care survey deficiency of scope and severity level "H" or higher during the survey review period. Homes that receive "G" level deficiencies, but no "H" level or higher deficiencies, and that correct the "G" level deficiencies within 30 days of the survey, will be eligible to receive 50% of the calculated incentive factor. Homes that receive no deficiencies higher than scope and severity level "F" will be eligible to receive 100% of the calculated incentive factor. The survey and certification review period will be the 12-month period ending one quarter prior to the incentive eligibility review date. The following table lists the incentive eligibility review dates and corresponding review period end dates.

Incentive Eligibility Effective Date:	Review Period End Date:
July 1	March 31st
October 1	June 30th
January 1	September 30th
April 1	December 31st

10) Rate Effective Date

Rate effective dates are determined in accordance with K.A.R. 129-10-19. The rate may be revised for an add-on reimbursement factor (i.e., rebased property fee), desk review adjustment or field audit adjustment.

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Retroactive adjustments, as in a retrospective system, are made for the following three conditions:

A retroactive rate adjustment and direct cash settlement is made if the agency determines that the base year cost report data used to determine the prospective payment rate was in error. The prospective payment rate period is adjusted for the corrections.

If a projected cost report is approved to determine an interim rate, a settlement is also made after a historic cost report is filed for the same period.

All settlements are subject to upper payment limits. A provider is considered to be in projection status if they are operating on a projected rate and they are subject to the retroactive rate adjustment.

Budget Adjustments

Effective for dates of service on or after July 1, 2016, the calculated per diem reimbursement for all nursing facilities shall be reduced by an amount equal to 4.47%. The per diem reduction will be calculated for each nursing facility by multiplying the total calculated per diem rate for each provider by 4.47%. The per diem reduction amount will be subtracted from each nursing facility's total calculated per diem to determine the facility's final rate.

INFLATION TABLE
EFFECTIVE 07/01/16

REPORT YEAR END (RYE)	MIDPOINT OF RYE	MIDPOINT OF RYE INDEX	MIDPOINT OF RATE PERIOD	MIDPOINT OF RATE PERIOD INDEX	HISTORICAL INFLATION FACTOR % *
12-12	06-12	1.255	06-15	1.370	9.163%
01-13	07-12	1.263	06-15	1.370	8.472%
02-13	08-12	1.263	06-15	1.370	8.472%
03-13	09-12	1.263	06-15	1.370	8.472%
04-13	10-12	1.267	06-15	1.370	8.129%
05-13	11-12	1.267	06-15	1.370	8.129%
06-13	12-12	1.267	06-15	1.370	8.129%
07-13	01-13	1.278	06-15	1.370	7.199%
08-13	02-13	1.278	06-15	1.370	7.199%
09-13	03-13	1.278	06-15	1.370	7.199%
10-13	04-13	1.283	06-15	1.370	6.781%
11-13	05-13	1.283	06-15	1.370	6.781%
12-13	06-13	1.283	06-15	1.370	6.781%
01-14	07-13	1.287	06-15	1.370	6.449%
02-14	08-13	1.287	06-15	1.370	6.449%
03-14	09-13	1.287	06-15	1.370	6.449%
04-14	10-13	1.286	06-15	1.370	6.532%
05-14	11-13	1.286	06-15	1.370	6.532%
06-14	12-13	1.286	06-15	1.370	6.532%
07-14	01-14	1.300	06-15	1.370	5.385%
08-14	02-14	1.300	06-15	1.370	5.385%
09-14	03-14	1.300	06-15	1.370	5.385%
10-14	04-14	1.305	06-15	1.370	4.981%
11-14	05-14	1.305	06-15	1.370	4.981%
12-14	06-14	1.305	06-15	1.370	4.981%
01-15	07-14	1.313	06-15	1.370	4.341%
02-15	08-14	1.313	06-15	1.370	4.341%
03-15	09-14	1.313	06-15	1.370	4.341%
04-15	10-14	1.320	06-15	1.370	3.788%
05-15	11-14	1.320	06-15	1.370	3.788%
06-15	12-14	1.320	06-15	1.370	3.788%
07-15	01-15	1.329	06-15	1.370	3.085%
08-15	02-15	1.329	06-15	1.370	3.085%
09-15	03-15	1.329	06-15	1.370	3.085%
10-15	04-15	1.336	06-15	1.370	2.545%
11-15	05-15	1.336	06-15	1.370	2.545%
12-15	06-15	1.336	06-15	1.370	2.545%
01-16	07-15	1.347	06-15	1.370	1.707%
02-16	08-15	1.347	06-15	1.370	1.707%
03-16	09-15	1.347	06-15	1.370	1.707%
04-16	10-15	1.349	06-15	1.370	1.557%
05-16	11-15	1.349	06-15	1.370	1.557%
06-16	12-15	1.349	06-15	1.370	1.557%

* = (Midpoint of rate period index / Midpoint of rye index) -1

COST CENTER LIMITATIONS EFFECTIVE 07/01/16

COST CENTER	UPPER LIMIT
Operating	$36.18
Indirect Health Care	$52.11
Direct Health Care	$117.10*
Real and Personal Property Fee	$9.72

* = Base limit for a facility average case mix index of 1.0169

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/16

NF ONLY

	INCENTIVE OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 75th percentile (5.09), or	$2.25
	CMI adjusted staffing < 75th percentile but improved >= 10%	$0.20
2	Staff turnover rate <= 75th percentile, 47% or	$2.25
	Staff turnover rate > 75th percentile but reduced >= 10%	$0.20
3	Medicaid occupancy >= 60%	$1.00
	Total Incentive Points Available	$5.50

PEAK INCENTIVE FACTOR EFFECTIVE 07/01/16

Level & Per Diem Incentive	Summary of Required Nursing Home Action	Incentive Duration
Level 0 The Foundation $0.50	Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in "The Foundation" timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 1 Pursuit of Culture Change $0.50	Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for Levels 1 & 2 in the same year. Homes that do not achieve Level 2 with three consecutive years of participation at Level 1 must return to a Level 0 or sit out for two years depending on KDADS and KSU's recommendation.	Available beginning July 1 of enrollment year. Incentive granted for one full fiscal year.
Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes must start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.

Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $3.00	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.
Level 5 Person-Centered Care Mentor Home $4.00	Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.	Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.

OWNER/ADMINISTRATOR LIMITATION TABLE EFFECTIVE 07/01/16

Number of Beds	Total Bed Days	Maximum Owner/Admin Compensation	Limit PPD	F/Y	Amount	Cost of Living State Emp.
15	5,490	$22,327	$4.07	76	10,000	---
16	5,856	$24,863	$4.25	77	10,280	2.800%
17	6,222	$27,399	$4.40	78	10,537	2.500%
18	6,588	$29,935	$4.54	79	11,301	7.250%
19	6,954	$32,471	$4.67	80	11,781	4.250%
20	7,320	$35,007	$4.78	81	12,617	7.100%
21	7,686	$37,543	$4.88	82	13,248	5.000%
22	8,052	$40,079	$4.98	83	14,109	6.500%
23	8,418	$42,615	$5.06	84	14,426	2.250%
24	8,784	$45,151	$5.14	85	15,147	5.000%
25	9,150	$47,687	$5.21	86	15,933	5.190%
26	9,516	$50,223	$5.28	87	16,411	3.000%
27	9,882	$52,759	$5.34	88	16,575	1.000%
28	10,248	$55,295	$5.40	89	17,238	4.000%
29	10,614	$57,831	$5.45	90	17,755	3.000%
30	10,980	$60,367	$5.50	91	18,021	1.500%
31	11,346	$62,903	$5.54	92	18,021	0.000%
32	11,712	$65,439	$5.59	93	18,111	0.500%
33	12,078	$67,975	$5.63	94	18,202	0.500%
34	12,444	$70,511	$5.67	95	18,407	1.125%
35	12,810	$73,047	$5.70	96	18,591	1.000%
36	13,176	$75,583	$5.74	97	18,591	0.000%
37	13,542	$78,119	$5.77	98	18,777	1.000%
38	13,908	$80,655	$5.80	99	19,059	1.500%
39	14,274	$83,191	$5.83	00	19,250	1.000%
40	14,640	$85,727	$5.86	01	19,250	0.000%
41	15,006	$88,263	$5.88	02	19,683	2.250%
42	15,372	$90,799	$5.91	03	19,683	0.000%
43	15,738	$93,335	$5.93	04	19,978	1.500%
44	16,104	$95,871	$5.95	05	20,577	3.000%
45	16,470	$98,407	$5.97	06	20,834	1.250%
46	16,836	$100,943	$6.00	07	21,355	2.500%
47	17,202	$103,479	$6.02	08	21,782	2.000%
48	17,568	$106,015	$6.03	09	22,327	2.500%
49	17,934	$108,551	$6.05	10	22,327	0.000%
50	18,300	$111,087	$6.07	11	22,327	0.000%
				12	22,327	0.000%
				13	22,327	0.000%
				14	22,327	0.000%
				15	22,327	0.000%

COMPILATION OF COST CENTER LIMITATIONS
EFFECTIVE 07/01/16

	BEFORE INFLATION					***AFTER INFLATION***				
	OPER	IDHC	DHC	RPPF	TOTAL	OPER	IDHC	DHC	RPPF	TOTAL
MEDIAN	31.43	43.24	85.58	9.26	169.51	32.99	45.31	91.28	9.26	178.84
MEAN	32.92	44.88	88.77	11.24	177.81	34.42	47.33	93.86	11.24	186.85
WTMN	32.32	44.05	89.10	11.76	177.23	32.89	46.54	93.28	11.76	184.47
# OF PROV	319					319				

COMPILATION OF ADMINISTRATOR, CO-ADMIN OWNER EXPENSE - O/A LIMIT
EFFECTIVE 07/01/16

	ADMINISTRATOR		CO-ADMINISTRATOR		TOTAL ADMN & C0-ADMN		OWNER	
	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD	TOTAL	PRD
HIGH	223,346	13.66	159,864	5.25	330,450	13.66	250,608	12.39
99th	182,801	11.42	159,864	5.25	187,159	11.42	201,096	11.21
95th	131,105	7.47	159,864	5.25	139,325	7.61	192,168	10.48
90th	106,944	6.45	82,036	3.04	112,031	6.58	138,885	6.81
85th	99,898	5.91	82,036	3.04	101,460	5.97	120,367	5.57
80th	94,504	5.60	73,281	2.67	95,015	5.64	98,451	4.30
75th	90,587	5.32	73,281	2.67	91,628	5.36	75,370	3.29
70th	86,208	4.91	54,464	1.45	86,472	4.93	71,528	2.91
65th	83,984	4.59	54,464	1.45	84,032	4.70	63,813	2.62
60th	81,239	4.38	39,310	1.21	81,396	4.43	56,038	2.52
55th	77,749	4.12	39,310	1.21	77,779	4.16	51,720	2.38
50th	75,530	3.88	39,310	1.21	75,535	3.90	48,412	2.20
40th	70,233	3.54	38,743	0.93	70,259	3.55	36,568	2.08
30th	65,015	3.07	38,743	0.93	65,015	3.08	23,970	1.59
20th	58,507	2.63	5,000	0.22	58,507	2.64	9,222	0.47
10th	37,793	2.15	1,873	0.17	37,793	2.18	4,223	0.11
1st	12,843	0.96	1,873	0.17	12,843	0.96	2,078	0.09
LOW	3,188	0.70	1,873	0.17	3,188	0.70	1,497	0.08
MEAN	76,787	4.20	53,349	1.72	78,331	4.25	62,152	2.94
WTMN	85,735	3.66	57,880	1.65	88,313	3.73	62,059	2.39
# of Prov	311		9		311		45	

COMPILATION OF NF-MH INCENTIVE POINTS AWARDED EFF. 07/01/16

INCENTIVE POINTS AWARDED	# OF PROVIDERS	PERCENTAGE
0	0	0.0%
1	5	50.0%
2	0	0.0%
3	2	20.0%
4	0	0.0%
5	3	30.0%
6	0	0.0%
7	0	0.0%
8	0	0.0%
TOTALS	10	100.0%

PEAK INCENTIVE AWARDED	# OF PROVIDERS	PERCENTAGE
$0.00	3	30.0%
$0.50	4	40.0%
$1.50	3	30.0%
TOTALS	10	100.0%

June 11, 2016

«ADMIN_NAME», Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«PROV_NUM»01
HP Enterprise Services Provider #: «EDS_PROV_N»

Dear «ADMIN_NAME»:

The per diem rate shown on the enclosed Case Mix Payment Schedule for state fiscal year 2017 has been forwarded to the Managed Care Organizations (MCOs) for processing of future reimbursement payments. The rate will become effective July 1, 2016.

The Kansas Department for Aging and Disability Services (KDADS), administers the Medicaid nursing facility services payment program on behalf of Kansas Department of Health and Environment. The rate was calculated by applying the published methodology, including applicable Medicaid program policies and regulations to the cost reports (Form MS 2004) data shown on the enclosed payment schedule.

Also enclosed may be an audit adjustment sheet showing adjustments made during the desk review of the 2015 calendar year end cost report. This information is intended to assist you with preparation of future cost reports. The calendar years of 2013, 2014 and 2015 will be used as the base years for the purpose of setting rates. These adjustments do not have any effect upon reimbursement. However, should you disagree with any adjustment, please email or mail me any information you have that supports your position. We will file the information with the cost report and will use that information to reevaluate the adjustments based on the documentation supplied.

If you do not agree with this action, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your request for fair hearing shall be in writing and delivered to or mailed to the agency so that it is received by the **Office of Administrative Hearings, 1020 S. Kansas Ave., Topeka, KS 66612-1311** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if you received this letter by mail). Failure to timely request or pursue such an appeal may adversely affect your rights.

If you have questions about the adjustments, please contact John Oliver at (785) 296-6457 or email at John.Oliver@kdads.ks.gov . For questions on the Medicaid Rate, please contact Facilities Reimbursement at (785) 296-4986 or email at Georgianna.Correll@ks.gov.

Sincerely,

Georgianna Correll, Facilities Reimbursement Manager
NF Reimbursement Program
Financial and Information Services

Enclosures

June 21, 2016

Administrator
«FAC_NAME»
«FAC_ADDRES»
«CITY», KS «ZIP»

Provider #: 104«PROV_NUM»01
EDS Provider #: «EDS_PROV_N»

Dear Administrator:

We forwarded the per diem rate shown on the enclosed Case Mix Payment Schedule for the first semi-annual rate period of state fiscal year 2017 to our fiscal agent, HP Enterprise Services. The rate will become effective July 1, 2016.

The Kansas Department for Aging and Disability Services (KDADS), administers the Medicaid nursing facility services payment program on behalf of Kansas Department of Health and Environment. The rate was calculated by applying the appropriate Medicaid program policies and regulations to the cost report(s) (Form MS 2004) data shown on the enclosed payment schedule.

Also enclosed may be an audit adjustment sheet showing adjustments made during the desk review of the 2015 calendar year end cost report. This information is intended to assist you with preparation of future cost reports.

If you disagree with the rate in the attached payment schedule, you have the right to request a fair hearing appeal in accordance with K.A.R. 30-7-64 et seq. Your written request for such an appeal should be delivered to or otherwise mailed so that it is received by the **Department of Administration, Office of Administrative Hearings, 1020 South Kansas Ave, Topeka, Kansas 66612-1311** within 30 days from the date of this letter. (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if this notice letter is mailed rather than hand delivered.) Failure to timely request or pursue such an appeal may adversely affect your rights on any related judicial review proceeding.

If you have questions regarding the Medicaid rate, other than those on desk review adjustments, please contact Facilities Reimbursement (785) 296-4986 or email Georgianna.Correll@ks.gov. For questions concerning desk review adjustments please contact John Oliver, Audit Manager, at (785) 296-6457 or by email at John.Oliver@ks.gov.

Sincerely,

Georgianna Correll
Facilities Reimbursement Manager
NF Reimbursement Program
Financial and Information Services

Enclosures

Kansas Medicaid / MediKan

Case Mix Schedule
1st - 2nd QTR 2017 ANNUAL

Current Provider Information

Provider Number:	HP Enterprises Provider Number:	1st QTR Medicaid CMI:	0.8900
Facility Name:	Area/County:	2nd QTR Medicaid CMI:	0.9200
Address:		Average Medicaid CMI:	0.9050 [a]
City/State/Zip:			
Administrator:			

Cost Report Statistics

Calendar Year Cost Reports Used For Base Data:	12/31/13	12/31/14	12/31/15	
Inflation Factor:	6.781%	4.981%	2.545%	
Facility Cost Report Period CMI:	0.9877	0.9313	1.0128	1.0169 [b]
Statewide Average CMI:	1.0130	1.0145	1.0231	
NF Or NF/MH Beds:	21	22	22	
Bed Days Available:	7,665	8,030	8,030	
Inpatient Days:	7,338	7,718	7,860	
Occupancy Rate:	95.7%	96.1%	97.9%	
Medicaid Days:	2,948	2,731	2,479	
Calc Days If Appl:	6,515	6,826	6,826	

Calculation of Combined Base Year Reimbursement Rate

Operating

Total Reported Costs:	$685,573	$737,496	$801,317		
Cost Report Adjustments:	($11,990)	($8,657)	($110,383)		
O/A Limit Adjustment:	$0	$0	$0		
Total Adjusted Costs:	$673,583	$728,839	$690,934		
Total Inflated Adjusted Costs:	$719,259	$765,142	$708,481		
Total Combined Base Cost:				$2,192,882	
Days Used In Division Oper:	7,338	7,718	7,860	22,916	
				95.69	Oper Per Diem
				36.18	Oper Per Diem Cost Limitation
				36.18	Oper Per Diem Rate (1)

Indirect Health Care

Total Reported Costs:	$510,427	$524,577	$529,358		
Cost Report Adjustments:	$0	$0	$0		
Total Adjusted Costs:	$510,427	$524,577	$529,358		
Total Inflated Adjusted Costs:	$545,039	$550,706	$542,830		
Total Combined Base Cost:				$1,638,575	
Days Used In Division IDHC:	7,338	7,718	7,860	22,916	
				71.50	IDHC Per Diem
				52.11	IDHC Per Diem Cost Limitation
				52.11	IDHC Per Diem Rate (2)

Direct Health Care

Total Reported Costs:	$828,435	$837,814	$897,191		
Cost Report Adjustments:	$0	$0	$373		
Total Adjusted Costs:	$828,435	$837,814	$897,564		
Total Inflated Adjusted Costs:	$864,611	$879,546	$920,407		
Total CMI Adjusted Costs:	$907,270	$958,122	$929,767		
Total Combined Base Cost:				$2,795,159	
Days Used In Division DHC:	7,338	7,718	7,860	22,916	
				121.97	Case Mix Adjusted DHC Per Diem
				117.10	DHC Per Diem Cost Limitation
				117.10	Allowable DHC Per Diem Cost [c]
			[c]*([a]/[b])	104.21	Medicaid Acuity Adjustment (3)

Real and Personal Property Fee

10.95	Real and Personal Property Fee
0.00	Inflation (0.000%)
0.00	RPPF Rebase Add On
10.95	RPPF Before Limit
9.72	RPPF Limitation
9.72	Allowable RPPF (4)

Calculation of Medicaid Rate

Operating, IDHC, And DHC Rates and RPPF (1) +(2) + (3) +(4):		202.22
Incentive Factor		4.50
PEAK 2.0		0.00
Bed Tax Pass Through		1.60
DME Pass Through		0.00
Minimum Wage Pass Through		0.00
Medicaid Rate Subtotal		208.32
Budget Adjustment Using (4.470%)		($9.31)
Total Medicaid Rate Effective	**7/1/2016**	**199.01**

Prepared by Myers and Stauffer on 06/22/2016

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/16

		Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio				
Tier 1: At or Above the NF 75th Percentile (5.09)		$ 2.25		$ 2.25
Tier 2: Below the NF 75th Percentile but Improved At or Above 10%		$ 0.20		$ 0.00
Cost Report Year Data:			5.13 12/31/2015	
2. Staff Turnover				
Tier 1: At or Below the NF 75th Percentile (47%)		$ 2.25		$ 2.25
Tier 2: Above the NF 75th Percentile but Reduced At or Above 10%		$ 0.20		$ 0.00
And Contract Nursing Labor Less than 10% of total DHC Labor Costs (Contract Labor 43%)			32%	
Cost Report Year Data:			12/31/2015	
3. Occupancy Rate				
Medicaid Occupancy At or Above 60%		$ 1.00		$0.00
Cost Report Year Data:			34% 12/31/2015	
Total Incentive before Survey Adjustment				$ 2.25
Survey Adjustment and Reduction	0%			$ 0.00
Final Incentive Awarded				**$ 2.25**
Peak 2.0 Incentive		$ 4.00		$ 0.00
Peak 2.0 Survey Adjustment and Reduction	0%			$ 0.00
Final PEAK 2.0 Incentive Awarded				$ 0.00

KANSAS MEDICAID
QUALITY AND EFFICIENCY OUTCOMES INCENTIVE FACTOR

Provider Number:
HP Enterprise Services Provider Number:

Facility Name:

Rate Effective Date: 07/01/16

	Incentive Possible	Facility Stats	Incentive Awarded
1. Case Mix Adjusted Nurse Staff Ratio			
Tier 1: At or Above 120% of NF-MH Median (3.56)	2		0
Tier 2: At or Above 110% of NF-MH Median of (3.27)	1		0
(NF-MH Median is 3.15 for an Average Statewide CMI of 1.0231)			
		2.79	
Cost Report Year Data:		12/31/2015	
2. Operating Expense			
At or below 90% of NF-MH Median ($18.60)	1		1
		$18.14	
Cost Report Year Data:		12/31/2015	
3. Staff Turnover			
Tier 1: At or Below the NF-MH 75th Percentile (39%)	2		2
Tier 2: At or Below the NF-MH 50th Percentile (61%)	1		0
And Contract Nursing Labor Less than 10% of Total DHC Labor Costs (0.0%)			
		39%	
Cost Report Year Data:		12/31/2015	
4. Staff Retention			
Tier 1: At or Above the NF-MH 75th Percentile (74%)	2		2
Tier 2: At or Above the NF-MH 50th Percentile (62%)	1		0
		83%	
Cost Report Year Data:		12/31/2015	
5. Occupancy Rate			
Total Occupancy At or Below 90%	1		0
		91%	
Cost Report Year Data:		12/31/2015	
Total Points Awarded			**5**
Incentive Before Survey Adjustment			$5.00
Survey Adjustment and Reduction	0%		$0
Final Incentive			**5.00**

Scoring:

Points	Per Diem
6 - 8	$7.50
5	$5.00
4	$2.50
0 - 3	$0.00

PEAK 2.0 Incentive		$0.50
Survey Adjustment and Reduction	0%	$0.00
Total PEAK 2.0 Incentive		**$0.50**

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

List of Contents

State of Kansas

KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES (KDADS)

INSTRUCTIONS FOR COMPLETING

THE NURSING FACILITY FINANCIAL AND STATISTICAL

REPORT

(FORM MS-2004)

PURPOSE

The purpose of this report is to obtain the resident-related costs incurred by nursing facilities (NF) and nursing facilities-mental health (NF-MH) in providing services according to applicable state and federal laws, regulations, and quality and safety standards. The regulations governing the completion of this report and NF reimbursement can be found in the Kansas Administrative Regulations (KAR) Chapter 129, Part 10; and Chapter 30, Part 10.

SUBMITTAL INSTRUCTIONS

1. The form MS-2004, Nursing Facility Financial and Statistical Report, will be available on the Kansas Department for Aging and Disability Services' website at http://www.kdads.ks.gov. Each nursing facility in the Kansas Medical Assistance Program will download or request the forms (cost report and census), before the end of the facility's reporting period.

2. Send the completed form MS-2004 and form AU-3903 (Census Summary) for each month of the reporting period, along with a signed copy of page 16 of the MS-2004 to costreports@kdads.ks.gov. If sent on CD-Rom or flash drive, send to the following address:

Kansas Department for Aging and Disability Services

New England Building

503 S. Kansas Avenue Topeka, Kansas

66603-3404

Attention: Nursing Facility Reimbursement Manager

3. In the event KDADS receives a cost report (MS-2004) in which the embedded formulas do not work or are missing, KDADS will return the cost report to be redone until such time as it is submitted in a completely functional version of the MS-2004.

4. All inquiries on completion of these forms should be directed to the Nursing Facility Audit Manager at (785) 296-6457.

GENERAL

The cost report is organized by the following sections and numbering schemes. Not all line numbers within each range are used.
General Information Lines 1-99
Schedule A, Operating Cost Center Lines 101-199

Schedule A, Indirect Health Care Cost Center Lines 201-299

Schedule A, Direct Health Care Cost Center Lines 301-399

Schedule A, Ownership Cost Center Lines 401-499

Schedule A, Non-Reimbursable/Non-Resident Related Expense Items Lines 501-599

Schedule B, Expense Reconciliation Lines 601-650

Schedule C, Statement of Owners and Related Parties Not Numbered

Schedule D, Statement Related to Interest... Lines 651-699

Schedule E, Balance Sheet Lines 701-750
Schedule F, Beginning & Ending Residual Balances Reconciliation Lines 751-799
Schedule G, Revenue Statement Lines 801-850
Schedules H(1), Related ACH Info, and H(2), Non-Resident Related... Lines 851-899
Schedule I, Fixed Asset, Depreciation & Amortization Questionnaire Lines 901-950
Schedule J, Employee Turnover Report Lines 951-999

1. Complete the forms accurately and legibly. Any report that is incomplete or is not legible shall be promptly returned to the provider. Failure to submit a complete cost report shall result in suspension of payment until the complete cost report is received.

2. All amounts must be rounded to the nearest dollar and sum to the total.

3. **DO NOT** add lines to the forms. Use "OTHER" lines for resident-related expenses not designated on the Expense Statement, Schedule A. Attach a breakdown or list of items included on "other" lines if necessary.

4. **DO NOT** cross out or re-title lines on the forms. **DO NOT** include more than one amount per line. If more than one amount or journal entry is combined, submit an attachment with explanation. The attachment should be **sorted by cost report line number** and should include subtotals.

5. Enter the ten (10) digit KDADS provider number and the ten (10) digit KMAP provider number on page 1 and in the blank space provided at the top of each schedule. **DO NOT** use any of the other identification numbers assigned to your facility.

6. Use the accrual method of accounting in reporting financial data. Revenues are reported in the period when **earned**, and not when received, and expenses are reported when **incurred**, not when paid.

7. Estimates of revenues and expenses are not acceptable.

8. All cost reports, historical or projected, must be for a period of 12 consecutive months except as provided in KAR 129-10-17 (e) (1). Providers who filed a projected cost report must file a historical report for the projection period and a historical report for the first calendar year following the end of the projection period.

9. All calendar year cost reports shall be received by the agency no later than the close of business on the last working day of February. All other historical cost reports covering a projection status period shall be received by the agency no later than the close of business on the last working day of the second month after the reporting period ends. The provider may request a one month extension of the due date by submitting the request in writing to the address in the submittal instructions within the time period allowed for filing the original cost report. The extension will be granted if the agency determines that the provider has shown good cause. NOTE: IF A COST REPORT IS RECEIVED AFTER THE DUE DATE WITHOUT AN APPROVED TIME EXTENSION, THE PROVIDER IS SUBJECT TO THE PENALTIES SPECIFIED IN KAR 129-10-17.

10. Each NF/NF-MH must maintain adequate accounting and/or statistical records.
Inadequate record keeping is cause for suspension of payments. KAR 129-10-15b. If non-NF/NF-MH program expenses have been commingled with the NF or NF-MH, see the instructions for provider adjustments on Schedule A, Expense Schedule.

11. Reimbursement rates (per diem) for NF: The per diem rate of reimbursement for those facilities participating in the Kansas Medical Assistance program is based on the reported costs and resident days as adjusted by a desk review of the cost report and payment limitations. Each cost report is also subject to a field audit to arrive at a final settlement for the period upon which the per diem rate was based.

12. **KANSAS ADMINISTRATIVE REGULATIONS:** Regulations governing NF Kansas Medical Assistance reimbursement may be obtained on the KDADS website at:-
http://www.aging.ks.gov/PolicyInfo_and_Regs/RateSetting/RateSetting_Regs_Index.
NOTE: SINCE THE REGULATIONS MAY BE CHANGED, THE PREPARER OF THE COST REPORT SHOULD CAREFULLY REVIEW THE MOST RECENT VERSION PRIOR TO COMPLETING THE FORM MS-2004 FOR SUBMISSION.

13. **NURSING FACILITIES ATTACHED TO HOSPITALS:** A nursing facility that is attached or associated with a hospital and shares expenditures shall submit the cost report (MS- 2004), census sheets (AU-3902), and the following Medicare schedules: W/S A, A-6, A-8, B Part I and B-1. Also include the working trial balance that includes both the hospital and the long-term unit. A "step-down process" will be run using the statistical information from W/S B-1 and the net expenses for cost allocation from Column 0 on W/S B Part 1. This will provide the indirect long-term care unit costs. Based on the long term care cost to net expense ratio, each department cost will be allocated to the appropriate line of the cost report. The total cost reported on the cost report should equal the long-term care total, Column 25, on W/S B Part 1. While costs for the long-term care unit are calculated using this step-down process, not all of these calculated costs may be considered allowable costs for the cost report (MS-2004). Any cost that would not be otherwise considered allowable for a long-term care unit, such as identifiable clinic costs, assisted living expenses, non-allowable legal expenses, or costs related to collection of bad debts, would not be an allowable cost. Once calculated, these costs should be listed on lines 501-514 as Non-Reimbursable & Non-Resident Related Items.

COST REPORT INSTRUCTIONS

COVER PAGE

PROVIDER IDENTIFICATION:

Lines 11-20: Complete these lines as indicated on the report form.

Lines 21-23: Check only one box.

Line 21 — Check if the cost data is for the calendar year report period and does not include any portion of a projection period.

Line 22 — Applies to projected cost reports for new providers and newly constructed facilities.

Line 23 — Applies to providers filing their first historical cost report for a non-calendar year.

Lines 26-32: Check only one box. Check the type of business organization which most accurately describes your provider status or explain on line 33, Other. Limited Liability Companies should check the box that matches their declaration for tax purposes.

NF and NF-MH:

Lines 43-43d: Enter the number of licensed NF or NF-MH beds under the BED COUNT column. Then calculate and record the number of bed days at that bed count (multiply the bed count by the number of calendar days this count is maintained, see example below). If a change in the number of beds has occurred during the reporting period, show the increase or decrease, the date of the change, the new bed count, and the bed days at that count.

Example of Bed Days Calculation:

Assume a home of 20 beds was increased on July 1 to 25 beds, the number of bed days for the period would be determined as follows:

January 1 to June 30 - 181 days x 20 beds =	3,620 bed days
July 1 to December 31- 184 days x 25 beds =	4,600 bed days
	8,220 bed days for period

Line 45: Record the bed count as of the ending date of the cost report period.

Line 46: **Total Bed Days** – Record the sum of the BED DAYS AT THIS COUNT column from lines 43-43d.

Line 48: **Total Resident Days** - The total number of resident days shall be determined in accordance with KAR 30-10-28. A resident day means that period of service rendered to a resident between the census-taking hours on two successive days and all other days for which the provider receives payment, either full or partial, for any Kansas Medical Assistance or non-Kansas Medical Assistance resident who was not in the facility (KAR 30-10-1a). The resident day total should include reserve days. If both the admission and discharge occur on the same day, it shall count as a resident day. If the provider does not make refunds on behalf of a resident for unused days in the case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day. Any bed days paid for the resident before an admission date shall not be counted as a resident day. The total resident day count for the cost report period shall be accurate. An estimate of the days of care provided shall not be acceptable. **The total resident days must** agree with the 12 month total as submitted on the Form AU-3902.

Day care and day treatment shall be counted as one resident day for 18 hours of service. The recipients of day care/treatment shall be listed on the monthly census summary of the Form (AU-3903) with the number of hours reflected on the appropriate day column.

Occupancy Percentage: Agency staff will determine this percentage.

Line 48a: **Total Kansas Medical Assistance Days** - Enter the total number of **Kansas Medical Assistance** days reported on the Form AU-3902. Partial, as well as full paid days must be included (please refer to KAR 30-10-28).

Line 48b: **Total Medicare Days** - Enter the total Medicare days in the report period.
OTHER FACILITY BEDS:

Lines 49: **Assisted Living/Res. Care** - Enter the number of beds for assisted living and residential health care. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 50: **Unlicensed Beds** - Enter the number of unlicensed beds i.e., apartments within the facility. If a change in the number of beds occurred during the reporting period, show the increase or (decrease) and the date of the change. Attach a schedule if additional space is needed to show all changes in the number of licensed beds.

Line 51: Enter the total number of other residential days with shared NF/NF-MH costs.
The total other residential days must agree with the 12 month total as submitted on the Form AU-3903. Do not include day care days on this line.

Line 52: Check the appropriate box regarding Medicare certified beds.

Line 53: Please indicate if the facility is a hospital based long term care (LTC) facility or a free standing facility.

SCHEDULE A - EXPENSE STATEMENT

Attach a copy of the working trial balance used to prepare the cost report.

Total Annual Hours Paid - Column 1 - Enter the total hours paid to the employees on each of the salary lines for the reporting period. Employees shall be reported on the appropriate salary line for their position classification.

Per Books or Federal Tax Return - Column 2 - Report the expenses reflected in the accounting records under the appropriate cost center (i.e., Operating, Indirect Health Care, Direct Health Care, Ownership and Non-Reimbursable). The total of all the expense lines (Column 1 - Line

599) shall reconcile to the income tax return and/or the accounting records.

Provider Adjustments - Column 3 - Enter the necessary adjustments to the expenses reported in Column 2 that are not resident-related according to the regulations and/or offset expense recoveries reported in the Revenue Statement, Schedule G. Attach a schedule if necessary.

Resident Related Expense - Column 4 - Enter the difference between Column 2 and Column 3. Please complete Column 4 even if no adjustments were made in Column 3, except for lines 501 through 514.

State Adjustments/Adjusted Resident Related Expenses - Columns 5 & 6 - Leave blank – FOR AGENCY USE ONLY

Expense Lines

General: All costs shall be reported on the designated expense lines. If all expense classifications are not addressed, report the amount on the line and in the cost center that most nearly describes the expense. For example, telephone expense is included in the Operating cost center. Therefore, the expense for telephone lines to the nurses' station shall **not** be reported in the Direct or Indirect Health Care cost center. See specific line instructions for more detail. **DO NOT CROSS OUT OR USE A LINE DESIGNATED FOR A PARTICULAR TYPE OF EXPENSE FOR SOME OTHER TYPE OF EXPENSE.**

The specific instructions, which follow, do not cover each line item of the expense statement, but are designed to cover items that may require additional explanation or examples.

All Salaries - Lines - 101-104, 201-213, and 301-306, - Salaries are compensation paid for personal services that were reported to the Internal Revenue Service (IRS). These lines, plus the owner/related party compensation lines, shall reconcile to your IRS 941 Report forms as adjusted by benefits or other bonuses.

Each facility must have a full time licensed administrator. Non-owner/related party administrator compensation shall be reported on line 101. Owner/related party administrator compensation shall be reported on line 121. A hospital-based long term care unit, under the jurisdiction of a hospital administrator, must report a percentage of the administrator's salary on line 101, and the salary of the staff person serving as an assistant administrator on line 102. Salaries and benefits of the administrator and co-administrator paid as central office costs shall be reported on lines 101, 102, and 119.

Report the salaries of the Direct Health Care Cost Center personnel on the most appropriate classification for lines 301-306. In the Indirect Health Care Cost Center, lines 205-210, are for reporting salaried employee therapists. DO NOT REPORT CONSULTANTS ON THESE LINES.

Employee Benefits - Lines 119, 219, and 319- Allocate employee benefits to the benefit lines in each cost center based on the percentage of gross salaries or the actual amount of expense incurred in each center. Employee benefits, if offered to substantially all employees may include, but are not limited to:

1. Employer's share of payroll taxes

2. State and federal unemployment contributions
3. Workers' compensation insurance
4. Group health and life insurance
5. Employee "non-cash" gifts
6. Moving/relocation expenses
7. Employee retirement plans
8. Employee parties - except alcoholic beverages
9. Profit sharing
10. Physical examinations
11. Malpractice insurance that specifically protects employees. This shall be specifically identified on the insurance bill from the agent.
12. Employee Uniforms
13. Employee Meals Employee

benefits shall not include:

1) Employee cash bonuses and/or incentive awards - these payments shall be considered additional compensation and be reported on salary lines.

2) Benefits given to owner/related parties - these benefits shall be reported on the owner/related party employee benefits lines (125, 225, 325).

Employee benefits with restrictions include:

1) Employee benefits offered to select non-owner/related party employees shall be reported as a benefit in the cost center in which the salary is reported. Do not include contracted labor consultants that could be reported on allocated consultant lines.

Contracted Labor - Lines130, 230 and 330. These lines shall be used to report all contract labor for services that would normally be provided by employees listed in the cost center.

Consultants - Lines131, 231-238, and 331. Consulting fees paid to related parties are subject to the restrictions of KAR 30-10-1a and KAR 30-10-23b-(c) and (d).
Report fees paid to professionally qualified non-salaried consultants. List the titles of consultants reported on line 238.

Owners and Related Party Compensation - Lines121, 122, 221, and 321. - Record the amount earned and reported to IRS for owner/related parties. In order to be allowed, the compensation must be paid within 75 days after close of the cost report period. The amount reported must be in agreement with entries made in Schedule C. Compensation may be included in allowable cost only to the extent that it represents reasonable remuneration for managerial and administrative functions, professionally qualified health care services and other services related to the operation of the nursing facility, and was rendered in connection with resident care. All compensation paid to an owner/related party shall appear on the appropriate lines above regardless of the label placed on the services rendered (See KAR 30-10-24).

"Other" - Lines 181 and 281 - "Other" or blank lines have been provided in the operating and indirect health care cost centers. Types of expense entered on these lines shall be identified and be applicable to the cost center unless further restricted. Attach a schedule to the cost report. **Failure to do so can cause unnecessary delay in the processing of your cost report.**

Management Consultant Fees - Line 131 - Report fees paid to non-related party management consultants. If the management services company is owned or controlled by the company or person(s) that own or control the facility, actual cost of the management company must be reported as central office costs and/or owner's compensation. See instructions for reporting central office costs - line 151.

Allocation of Central Office Costs - Line 151 - All providers with more than one facility and pooled administrative costs shall report allocated costs on line 151. All facilities, including the central office, must

use the same reporting period. Central office costs shall be reported in accordance with KAR 129-10-27. **Attach a detailed schedule listing the central office costs and method of allocation to each facility.** Submit a copy of the Medicare Home Office Cost Report if applicable. The same method of allocation used on the Medicare Cost Report must be used in the Medicaid Cost Report.

Allowable central office costs are subject to the following conditions:

— Only expense allocations related to Kansas facilities will be allowed.

— Purchases from related-party vendors - Costs of resident-related goods and services supplied to the central office by related parties will be allowed at the lower of the cost to the vendor or the charge to the central office;

— Costs directly attributable to a specific provider or non-provider activity must be allocated directly to the entity for which they were incurred;

— Salaries of owner/related parties - Any of these costs that are included in central office costs must be reported on line 121;

— Central office bulk purchases of adult care home supplies - These expenses may be allocated to the supplies lines in the appropriate cost centers, if the allocation method is adequately documented; and

— Consultants - Costs directly applicable to the indirect and direct health care cost centers may be reported on the applicable consultant lines in these cost centers.

Office Supplies and Printing - Line 152 - Report all office supplies, postage, duplicating and printing expenses on this line. The printing and duplicating of forms are considered to be an administrative expense and shall **not** be reported in any other cost center. **The exception to this rule is medical records forms that may be reported on line 351, Nursing Supplies.**

Telephone and Other Communication - Line 153 - Report routine telephone and communications expense on this line regardless of the department or cost center benefit.

Travel - Line 154 - Report administrative and staff travel expenses that are related to resident care. **Vehicle costs must be documented by detailed expense and mileage records kept at the time of the travel activity.** Estimates shall not be acceptable. Exceptions:

1) Long term or recurring vehicle lease expense for business purposes shall be reported on line 402.
2) Expenses associated with the personal use of a vehicle are not allowable unless reported within otherwise allowable limits of compensation.
3) Costs related to "in town" entertainment are non-allowable.
4) Travel expenses related to **Provider** board meetings are non-allowable.
5) Resident transportation expense shall be reported on line 258.

Advertising & Recruitment- Line 155 - Report allowable advertising and recruitment expense on this line. This line shall be used for fees paid to employment agencies, employment advertisements and ads in telephone directories. Fund raising, public relations, advertising for resident utilization and sponsorships are **not allowable** and shall be reported on line 505.

Licenses and Dues - Line 156 - Report allowable licenses and dues expense on this line. Refer to KAR 30-10-23a for non-reimbursable dues and membership costs. Personal automobile club memberships are not allowable unless reported as compensation.

Accounting and Data Processing - Line 157 - Report accounting expense on this line, except fees paid to owner/related party firms or individuals which must be reported on the owners compensation line 121.

Data processing expense related to financial management (i.e., accounting, payroll, budgeting, etc.) shall be reported on this line.

Liability Insurance - Line 158 - Report liability insurance expense on this line.

Other Insurance - Line 159 - Report property insurance expense on this line. Workers' compensation and employee health and life insurance expense shall be reported on employee benefit lines. Insurance premiums on lives of owners and related parties are not an allowable expense, and shall be reported on line 505.

Interest - Line 160 - Report the paid interest expense paid related to operating loans and equipment purchases. Submit copies of each new note of $5,000 or more for the year originated. Interest on loans for real and personal property that is included in a re-base, in accordance with KAR KAR 30-10-25, shall be reported with real estate interest on line 401. Allowable interest expense shall be limited to the annual expense submitted on the loan amortization schedule, unless the loan principal is retired before the end of the amortization period, or working capitol loans when the period is one(1) year or less. Any interest income shall be offset to this line, with any remaining to be offset to line 401.

Legal - Line 161 - Report allowable legal expense on this line, subject to KAR 30-10-1a, 23a, and 23b. Allowable fees paid to owner/related party firms or individuals must be reported as owner/related party compensation on line 121.

Criminal Background Check - Line 162 - Report the amount expended for criminal background checks for all employees on this line.

Real Estate and Personal Property Taxes - Line 163 - Report all real and personal property taxes on this line.

Maintenance & Repairs - Line 164 - Report all maintenance and repair expenses applicable to the building, grounds, equipment and vehicles.

Operating Supplies - Line 165 - Report supplies expense incidental to the operation and maintenance of the building, grounds, and equipment.

Small Equipment - Line 166 - Equipment purchases of $1,000 to $5,000 that were not capitalized must be expensed on this line. Equipment purchases of $1 to $999 may be reported in the cost center of benefit as a supply expense.

Other - Line 181 - Report miscellaneous expenses incidental to the operation and/or maintenance of the facility and grounds. These include but are not limited to amortization of administrative organizational and/or start-up costs, ~~trash hauling,~~ snow removal and lawn care. This line shall be used for training and educational expenses for employees with salaries reported in the operating cost center.

Housekeeping Salaries - Line 202 - Report the hours paid and salaries of housekeeping and janitorial staff involved in floor care and in cleaning of the building.

Therapy Salaries - Lines 205-210 - Report the hours paid and salaries of therapists who are directly involved in providing health care. Note: Physical, occupational, speech, and respiratory therapy salaries are subject to the same allowance as therapy consultants.

Medical Records/Resident Activities/Social Worker/ Other Salaries - Lines 204, 211-213 - Report the hours paid and salaries on the appropriate line for these classifications. Specify the job classification of other indirect health care salaries.

Consultants - Lines 231-238 - Record the fees paid to consultants on the appropriate lines. Provider adjustments for physical therapy, occupational therapy, speech therapy, respiratory therapy, and other therapies shall be in accordance with KAR 129-10-15a(b). Submit a work paper with the cost report that shows the units and calculation of the allowable Medicaid/Medikan therapy expenses.

Utilities Except Telephone - Line 251 - Report expenses for gas, water, electricity, heating oil, trash hauling, etc. Cablevision may be considered a utility or resident activity expense.

Food - Line 252 - Report all food costs. Nutritional supplements are to be included on line 351. The provider shall be required to keep records on the total number of meals served to residents, employees, guests, and outside programs. If the food expense for the employees, guests, and outside programs is included in the MS-2004 expenses, the expense should be offset against the dietary cost center as follows:

A. Line 201 - Dietary Salaries
Line 219 - Dietary Portion Employee Benefits
Line 221 - Dietary Owner/Related Party Compensation Line 231 - Dietary Consultant
Line 252 - Food
Line 253 - Dietary Supplies Line 281 -
Other
Total Dietary Cost ÷ Total Number of Meals Served = Cost Per Meal

B. Cost per meal x number of meals served to employees, guests, and outside programs = amount of offset

C. The cost of free employee meals shall be allocated and reported on employee benefit lines. If employees pay less than the cost for a meal, the difference between the meal revenue and cost may be reported as an employee benefit.

Dietary Supplies - Line 253 - Report supplies expense directly related to the preparation and service of food to the residents unless further restricted by another expense line (i.e., printed menus are reported on line 152 - Office Supplies and Printing). Examples include but are not limited to paper goods, kitchen utensils, etc.

Linen and Bedding Material - Line 254 - Report linen and bedding material expenses on this line.

Laundry and Linen Supplies - Line 255 - Report all supplies expense directly related to laundry and linen services for the residents, unless restricted by another line.

Housekeeping Supplies - Line 256 - Report all supplies expense related to keeping the building clean and sanitary. Floor care supplies shall be expensed on this line.

Resident Activity Supplies - Line 257 - Report the supplies expense involved in providing resident activities. This does not include the cost of newsletters, which should be included in line 152.

Resident Transportation - Line 258 - Report resident transportation expense incurred for non- emergency medical, shopping, activities, etc., in which the residents are the primary passengers. **Do not include vehicle lease, interest, depreciation, insurance or other expense restricted to another expense line.**

Acceptable methods of allocating cost to line 258, Resident Transportation are as follows:

1) Allocated at a set rate per mile. The rate would be determined by dividing total vehicle expense, not restricted to another expense line, by the total miles. The IRS allowed rate per mile is not acceptable because it includes factors for depreciation, insurance and repairs.

2) Allocated directly per the following formula:

Resident Travel Miles / Total Miles	x	Total Vehicle Expenses not Restricted to Another Expense Line	=	Resident Travel Expense

3) If private vehicles are used to transport residents, the entire amount of the reimbursement paid to the employee for use of the vehicle is allowable as Resident Transportation. The rate of reimbursement must, however, be reasonable.

Barber and Beauty – Line 259 – Report the barber and beauty expenses on this line. If you charge residents for these services offset the expense up to the revenue received in column 3.

Nursing Aide Training - Line 260 - Report the costs of fees, tuition, books, etc. for education or training seminars provided to aides with salaries reported on lines 303, 304, and 306. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Other Health Care Training - Line 261 - Report the costs of fees, tuition, books, etc., for education or training seminars to employees, except aides reported on line 303, 304 and 306, with salaries reported in the Indirect or Direct Health Care cost centers. Travel, lodging and meals associated with the education/seminars may be reported on this line.

Aides- Lines 303, 304, and 306 - Record the hours paid and salaries of aides involved in direct resident care, on the line that most appropriately defines their classification.

Nursing Supplies - Line 351 - Report expenses of all **routine** supplies, including all durable medical equipment, directly related to the provision of nursing and/or health related services for residents, unless further restricted by another expense line. Medical records forms may be expensed on this line. Nutritional supplements shall be reported on this line.

Total Rate Formula Costs - Line 399 - Enter the sum of the totals in the Operating, Indirect Health Care, and Direct Health Care cost centers.

Interest on Real Estate - Line 401 - Report all paid interest expense incurred for the acquisition or construction of real estate. Describe fully on Schedule D. Include amortization expense for loan costs. The interest for equipment and furnishings purchased along with the building shall be reported on this line. Report interest expense on loans for real and personal property included in a re-base of the real and personal property fee, in accordance with KAR 30-10-25e.

Rent or Lease Expense - Line 402 - Report all recurring rent and lease expense regardless of the item and use except computer software lease expense which can be reported in the cost center of benefit or line 157, Accounting and Data Processing.

Amortization of Leasehold Improvement - Line 403 - Report only amortization of leasehold improvements on this line. Leasehold improvements are defined as betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

Depreciation Expense - Line 404 - This amount must be computed by the straight-line method. Such amounts must be reconciled to a detailed depreciation schedule. The determination of capitalized property must be in conformity with Generally Accepted Accounting Principles. **Attach a detailed depreciation schedule to the cost report.**

Non-Reimbursable & Non-Resident Related Items

General: Lines 501-514- Provider adjustments must be made in column 3 that offset column 2 expenses in total. Column 4 will show zero expenses.

Fund Raising/Public Relations/Advertising for Resident Utilization - Line 505- Include non- allowable advertising expenses. See Line 155 – Advertising and Recruitment.

Drugs (Pharmaceuticals) - Line 508 - Report expenses for prescription drugs and other items not covered as a routine item in KAR 129-10-15a.

Resident Purchases - Line 511 - Report the expense for items purchased for residents but not listed as routine services or supplies in KAR 129-10-15a.

Bed Tax Assessment - Line 512 – Report the bed tax assessment for the year.

SCHEDULE C - STATEMENT OF OWNERS AND RELATED PARTIES

General: List all owners of the provider entity with 5% or more ownership interest and all related parties (KAR 3 0 -10-24). Fill out Schedule C completely and accurately. Attach an additional schedule if more explanation or space is needed. Providers shall base all allocations on reasonable factual information and make the information available on request. Such information shall include details of dates, hours worked, nature of work performed, how it relates to resident care and the prevailing wage rates for such activities.

ENTER – Name and Address

Column (1) - % of ownership (if applicable) or state the relationship to owner

Column (2) - % of time devoted to this facility per customary workweek

Column (3) - Total salaries, drawings, consulting fees, and other payments to owners and related parties as defined in KAR 30-10-1a and KAR 30-10-24.

Column (4) - List the titles, functions or descriptions of the jobs performed or transactions made with all owners and related parties. The job titles should correspond with those included in the Owner/Related Party Salary Chart (please refer to KAR 30-10-24).

Column (5) - Enter the distribution by cost report line item of the total compensation incurred for all job functions. Owner/related party compensation shall be reported on the owner compensation expense lines (121, 122, 221, and 321) in Schedule A.

Totals - The total compensation in Column 3 and Column 5 should agree. These two totals should also agree with the total of lines 121, 122, 221, and 321 from Schedule A.

SCHEDULE D - STATEMENT RELATED TO INTEREST ON ALL BONDS, LOANS, NOTES, AND MORTGAGES PAYABLE

Note: Submit copies of loan agreements and amortization schedules with this cost report for all loans of $5,000 or more. Failure to document interest expense is cause for disallowance. (KAR 30-10-15b).

Column (1) - Enter the original date and duration of the loan in months.

Column (2) - Enter the interest rate. If it is a variable rate, provide the range of the interest rates for the cost report period.

Column (3) - Enter the amount of the loan.

Column (4) - Enter the unpaid principal balance at the end of the cost report period. The total of Column 4, Line 667, must agree with the Balance Sheet, Schedule E.

Column (5) - Enter the total amount of interest and principal payments made during the cost report year.

Column (6) - Enter the total amount of interest incurred during the cost report year. The total of Column 6, Line 667 must agree with the total interest reported on Schedule A, Lines 160 and 401.

Lines –651-666 - Enter each lender's name, address and the items financed. Indicate whether the interest expense was reported on line 160 or line 401 of Schedule A. If interest expense on a loan is pro-rated to both lines, show the breakdown.

Line 667 - Enter the totals of Column 4 - Unpaid Balance and Column 6 - Interest Expense, for Lines 651-666 as reported on lines 160 and 401 in Schedule A.

SCHEDULE E - BALANCE SHEET

General: The balance sheet should be prepared from the books of the specific facility for which the cost report is filed. In other words, chain units should report only those balance sheet accounts that relate to the particular facility for which the cost report applies. Subject to the above, the balance sheet must be prepared in conformity with Generally Accepted Accounting Principles. Report all ownership claims that are customarily used by your particular type of entity. A partial listing of these accounts by type of entity follows:

Individual Proprietor	Owner's Capital
Partnership	Partner's Capital Account
Not-For-Profit Entities	Fund Balance
Corporation	Common Stock, Additional Paid in Capital, Retained Earnings
Chain Unit -- All Chain Units	Central or Home Office Account (regardless of type of ownership)

NOTE: Beginning of period account balances shall be reported for providers allowed to submit projected cost reports.

SCHEDULE F - RECONCILIATION OF BEGINNING AND ENDING RESIDUAL BALANCES

General: This schedule explains the change in owner's equity or the fund balance from the beginning to the end of the cost reporting period.

Beginning Balance

Line 751 - Enter the beginning owner's equity or fund balance. This is the total of Column 2 lines 727-729 in the Balance Sheet, Schedule E.

Increase to Owner's Equity or Fund Balance Line 752 - Enter

total revenue from Schedule G, Column 1, Line 822.

Line 753 - Enter the total of cash or other assets transferred or contributed by the owners.

Line 754 - Enter the total of cash or other assets transferred or contributed by the central office.

Line 755 - Enter the proceeds from the sale of common stock.

Line 756 & 757 - Enter and specify all other transactions which increase the residual owner equity or fund balance accounts.

Line 758 - Enter the total of Lines 752-757.

Decreases to Owner's Equity or Fund Balance Line 761 - Enter the

total expenses per Schedule A, Column 2, Line 599.

Line 762 - Enter total of cash or other assets withdrawn by the owners but not reported in the Expense Statement, Schedule A.

Line 763 - Enter total cash or other assets withdrawn by the central office.

Line 764 - Enter the total of duly declared dividends paid to stockholders.

Line 765 - Enter the depreciation expense in excess of the straight line method UNLESS reflected as a negative adjustment in Schedule A, Line 404, Column 3.

Line 766 & 767 - Enter and specify all other transactions which decrease the residual owner equity or fund balance accounts.

Line 768 - Enter the totals of Lines 761-767.

Ending Balance

Line 769 - Enter the net of adding lines 751 and 758 and subtracting line 768. The balance at the end of the period (line 769) should equal the total of Column 4, lines 727-729 in the Balance Sheet, Schedule E.

SCHEDULE G - REVENUE STATEMENT

Column 1 - Enter the revenues from the general ledger accounts on the appropriate lines. Revenues from services not designated on this schedule must be identified and reported on line 821. The amount of the total revenue entered on line 822, Column 1 must also be entered on line 752, Beginning and Ending Residual Balances Reconciliation, Schedule F.

Column 2 - Enter the amount of the offset to the appropriate expense accounts. **Note the Following:** The amount of the offset should be the cost of reimbursable expenses. Non- reimbursable items (i.e. Vending) are offset at cost.

Column 3 - Enter the line number of the expense reported on the Expense Statement, Schedule A, against which the offset has been made. The amount of the offset must be entered in Column 3, Provider Adjustments, on the Expense Statement, Schedule A.

Line 807 - Routine Nursing supplies sold to private pay residents.

There is no offset required for routine items covered under KAR 1 2 9 -10-15a that are sold to private pay residents.

Line 810 - Resident Purchases/Non Routine Items Sold - Enter the total of all reimbursements for personal purchases not designated as routine items in KAR 129-10-15a.

Line 817- Adult Day Care/Treatment Income - Enter total revenue from all sources for adult day care and day treatment programs.

Line 820 – Non-Nursing Facility Residential Income – Enter total revenue from assisted living, residential care, and apartments.

SCHEDULE H(1) - STATEMENT OF RELATED ADULT CARE HOME INFORMATION

General: All Kansas facilities operated by common ownership or related parties shall be listed. Common ownership and related parties are defined in KAR 30-10-1a. Additional schedules shall be attached as necessary. If the provider is a publicly held entity, provide the annual report and a Form 10-K.

SCHEDULE H(2) – STATEMENT OF NON-RESIDENT RELATED ACTIVITIES

General: Indicate any non-resident related activities that you participate in at the facility for which you are reporting by marking yes in column (1). If adjustments were made on schedule A for any of these activities indicate so by marking yes in column (2). List additional activities that are not identified on the lines provided. Attach a separate schedule if additional room is required.

SCHEDULE I - FIXED ASSET, DEPRECIATION AND AMORTIZATION QUESTIONNAIRE

General: Each question shall be answered completely and accurately.

Lines 902-909 - Complex Capital Structures:
Attach a complete explanation of the ownership/management structure of the nursing facility including owners with 5% or more interest in the property and/or business, related parties as defined in KAR 30-10-1a, and all relevant contracts, leases, and assignments. This information must be accurate and comprehensive enough to present a true and clear account of the ownership and control of the adult care home.

Line 911 - If the facility is leased, a copy of the original lease agreement and subsequent amendments and/or agreements shall be submitted and on file with the agency. A provider making payments under Industrial Revenue Bonds with a nominal purchase upon maturity shall report the cost of ownership versus lease expense.

Line 914 - A new provider that purchases a facility shall submit a copy of the loan agreement(s), and any other pertinent information concerning the transaction.

Line 915 - Submit a copy of the DETAILED depreciation schedule with the cost report. Each asset shall be listed with the cost, date of purchase, life, salvage value, accumulated depreciation expense and current depreciation expense. Depreciation must be computed using the STRAIGHT LINE method. If the provider has filed a detailed depreciation schedule with the agency, an annual submission of addition and deletion schedules and a summary of depreciation expense are permissible.

SCHEDULE J - EMPLOYEE TURN OVER REPORT

Column 2 - Show the total number of employees at the beginning of the cost report period for each classification.

Column 3 - Show the total number of employees hired during the cost report period for each classification.

Column 4 - Show the total number of employees who ended employment during the cost report period for each classification.

Column 5 - Show the total number of employees at the end of the cost report period for each salary classification.

Column 6 - From the total number of employees listed in column 5, show how many are full-time and how many are part-time.

Column 7 – From the total number of employees listed in column 5, show how many were included in column 2 as employees at the beginning of the cost report period.

The number of employees listed in column 2, plus the number of employees listed in Column 3, less the number of employees reflected in Column 4, should equal Column 5. Please explain any discrepancy. The W-2's are an excellent source of information for the calendar year end cost report.

ATTENTION

The cost report is not considered complete unless all required documents are submitted with the cost reports. Review the list of questions/documents following Schedule J in the Cost Report.

DECLARATION STATEMENT

Declaration by Owner; Partner; or Officer of the Corporation, City or County which is the Provider. The cost report is not considered complete unless signed by an owner or authorized agent of the facility and/or business and the preparer. If person signing is not an owner or partner, documentation or a resolution stating their authority to sign needs to be attached. It is not required, if it has been submitted previously and has not changed. If the facility/business owner and the preparer are the same individual, please sign both spaces. Print the names of the owner/authorized agent and preparer in the space provided. **PLEASE READ DECLARATION STATEMENT.**

This page is reserved for future use.

129-10-17. Cost reports. (a) Historical cost data.

(1) For cost reporting purposes, each provider shall submit the "nursing facility financial and statistical report," form MS-2004, revised August 2004 and hereby adopted by reference, completed in accordance with the accompanying instructions. The MS-2004 cost report shall be submitted on diskette, using software designated by the agency for cost report periods ending on or after December 31, 1999.

(2) Each provider who has operated a facility for 12 or more months on December 31 shall file the nursing facility financial and statistical report on a calendar year basis.

(b) Projected cost data.

(1) Projected cost reports.

(A) If a provider is required to submit a projected cost report under K.A.R. 129-10-18 (c) or (e), the provider's rate shall be based on a proposed budget with costs projected on a line item basis.

(B) The projected cost report for each provider who is required to file a projected cost report shall begin according to either of the following schedules:

(i) On the first day of the month in which the nursing facility was certified by the state licensing agency if that date is on or before the 15th of the month; or

(ii) on the first day of the following month if the facility is certified by the state licensing

agency on or after the 16th but on or before the 31st of the month.

(C) The projected cost report shall end on the last day of the 12-month period following the date specified in paragraph (b)(1)(B), except under either of the following:

(i) The projected cost report shall end on December 31 if that date is not more than one month before or after the end of the 12-month period.

(ii) The projected cost report shall end on the provider's normal fiscal year-end used for the internal revenue service if that date is not more than one month before or after the end of the 12-month period and the criteria in K.A.R. 129-10-18 for filing the projected cost report ending on December 31 do not apply.

(D) The projected cost report period shall cover a consecutive period of time not less than 11 months and not more than 13 months.

(E) The projected cost report shall be reviewed for reasonableness and appropriateness by the agency. The projected cost report items that are determined to be unreasonable shall be disallowed before the projected rate is established.

(2) Projected cost reports for each provider with more than one facility.

(A) Each provider who is required to file a projected cost report in accordance with this subsection and who operates more than one facility, either in state or out of state, shall allocate central office costs to each facility that is paid rates from the projected cost data. The provider shall allocate

the central office cost at the end of the provider's fiscal year or the calendar year that ends during the projection period.

(B) The method of allocating central office costs to those facilities filing projected cost reports shall be consistent with the method used to allocate the costs to those facilities in the chain that are filing historical cost reports.

(c) Amended cost reports.

(1) Each provider shall submit an amended cost report revising cost report information previously submitted if an error or omission is identified that is material in amount and results in a change in the provider's rate of $.10 or more per resident day.

(2) An amended cost report shall not be allowed after 13 months have passed since the last day of the year covered by the report.

(d) Due dates of cost reports.

(1) Each calendar year cost report shall be received not later than the close of business on the last working day of February following the year covered by the report.

(2) A historical cost report covering a projected cost report period shall be received by the agency not later than the close of business on the last working day of the second month following the close of the period covered by the report.

(3) Each cost report approved for a filing extension in accordance with subsection (e) shall be received not later than the close of business on the last working day of the month approved for the extension request.

(e) Extension of time for submitting a cost report.

(1) A one-month extension of the due date for the filing of a cost report may be granted by the agency if the cause for delay is beyond the control of the provider. The causes for delay beyond the control of the provider that may be considered by the agency in granting an extension shall include the following:

(A) Disasters that significantly impair the routine operations of the facility or business;

(B) destruction of records as a result of a fire, flood, tornado, or another accident that is not reasonably foreseeable; and

(C) computer viruses that impair the accurate completion of cost report information.

(2) The provider shall make the request in writing. The request shall be received by the agency on or before the due date of the cost report. Requests received after the due date shall not be accepted.

(3) A written request for a second one-month extension may be granted by the Kansas medical assistance program director if the cause for further delay is beyond the control of the provider.

The request shall be received by the agency on or before the due date of the cost report, or the request shall not be approved.

(f) Penalty for late filing. Each provider filing a cost report after the due date shall be subject to the following penalties:

(1) If the complete cost report has not been received by the agency by the close of business on the due date, all further payments to the provider shall be suspended until the complete cost report has been received. A complete cost report shall include all the required documents listed in the cost report.

(2) Failure to submit the cost report within one year after the end of the cost report period shall be cause for termination from the Kansas medical assistance program.

(g) Balance sheet requirement. Each provider shall file a balance sheet prepared in accordance with cost report instructions as part of the cost report forms for each provider.

(h) Working trial balance requirement. Each provider shall submit a working trial balance with the cost report. The working trial balance shall contain account numbers, descriptions of the accounts, the amount of each account, and the cost report expense line on which the account was reported. Revenues and expenses shall be grouped separately and totaled on the working trial balance and shall reconcile to the applicable cost report schedules. A schedule that lists all general ledger accounts grouped by cost report line number shall be attached.

(i) Allocation of hospital costs. An allocation of expenditures between the hospital and the long-term care unit facility shall be submitted through a step-down process prescribed in the cost report instructions.

(j) Interest documentation requirement. A signed promissory note and loan amortization schedule shall be submitted with the cost report for all fixed-term loan agreements with interest reported in the operating cost center. For working capital loans for one year or less, amortization schedules shall not be required. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008.)

129-10-25. Real and personal property fee. (a) A real and personal property fee shall be developed by the agency in lieu of an allowable cost for ownership or lease expense, or both. The fee shall be facility-specific and shall not change as a result of change of ownership, a change in lease, or reenrollment in the medicaid program by providers. An inflation factor may be applied to the fee on an annual basis.

The real and personal property fee shall include an appropriate component for the following:

(1) Rent or lease expense;

(2) interest expense on a real estate mortgage;

(3) amortization of leasehold improvements; and

(4) depreciation on buildings and equipment;

(b)(1) The real and personal property fee shall be determined based on one of the following methodologies:

(A) For providers enrolled in the Kansas medical assistance program with a real and personal property fee for each facility, the real and personal property fee shall be the sum of the property allowance and value factor.

(B) For providers reenrolling in the Kansas medical assistance program or providers enrolling for the first time but operating in a facility that was previously enrolled in the program, the real and personal property fee shall be the sum of the last effective property allowance and the last effective value factor for the facility.

(C) The real and personal property fee for a newly constructed nursing facility or a nursing facility that enters the Kansas medical assistance program and has not had a fee established previously shall be calculated based on the following methodology:

(i) A projected real and personal property fee shall be calculated using a projected cost report by dividing the total of the four real and personal property fee components reported in the ownership cost center by the greater of the total number of resident days reported or 85 percent of the licensed capacity for the cost report period.

(ii) A historical real and personal property per diem shall be calculated using a historical cost report by dividing the total of the four line items reported in the ownership cost center by the greater of the total number of resident days reported or 85 percent of the licensed capacity for the cost report period.

(iii) A settlement between the projected and historical rates, which shall include the real and personal property fee, shall be made in accordance with K.A.R. 129-10-18(e).

(2) The real and personal property fee shall be subject to an upper payment limit. The upper payment limit for the real and personal property fee shall be determined by the median real and personal property fee plus a percentage of the median. The percentage factor applied shall be determined by the secretary.

(c)(1) The depreciation and amortization component of the real and personal property fee shall meet these criteria:

(A) Be identifiable and recorded in the provider's accounting records;

(B) be based on the historical cost of the asset as established in this regulation; and

(C) be prorated over the estimated useful life of the asset using the straight-line method.

(2)(A) Appropriate recording of depreciation shall include the following:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Each provider shall report gains and losses on the sale of depreciable personal property on the cost report at the time of the sale. The provider shall record trading of depreciable property in accordance with the

income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets shall not be recognized in the year of trade but shall be used to adjust the basis of the newly acquired property.

(3) The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, which may include legal fees, accounting fees, travel costs, and the cost of feasibility studies.

(d) Any provider may request that the agency rebase the real and personal property fee. Providers shall submit rebase requests for completed capital improvement projects or phases of capital improvements projects. The following methodology shall be used to determine a revised real and personal property fee based on the rebase request.

(1) Rebase requests shall be reviewed to determine a revised real and personal property fee if the provider meets the following capital expenditure thresholds:

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem based on the interest expense, depreciation expense, and amortization of leasehold improvements shall be added to the real and personal property fee in effect on the date that the rebase is made effective. Interest expense reported in the operating cost center shall not be included in the request for a rebase of the real and personal property fee. Interest on loans for real and personal property that is included in a rebase shall be reported with mortgage interest in the ownership cost center.

(3) The number of resident days used in the denominator of the real and personal property fee calculation shall be based on the total number of resident days from the most recent desk-reviewed cost report to

rebase the property fee. The resident days shall be subject to the 85 percent minimum occupancy requirement, including any new beds documented in the request for a rebase.

(4) The revised real and personal property fee shall be subject to the upper payment limit in effect on the date the rebase is made effective.

(5)(A)If the number of beds of an existing nursing facility is increased by the construction of a new addition to the existing facility, the real and personal property fee established through the rebase shall be effective according to either of the following schedules:

(i) On the first day of the month in which the new beds were certified if the certification date was on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the beds were certified if the certification date is on or after the 16th of the month.

(B) If the capital expenditure that is the basis for the rebase request is not related to an increased number of beds, the real and personal property fee established through the rebase shall be effective according to either of the following schedules:

(i) on the first day of the month in which the complete documentation is received, if the request is received on or before the 15th of the month; or

(ii) on the first day of the month following the month in which the complete documentation is received, if the request is received on or after the 16th of the month.

(C) Complete documentation shall include the following:

(i) The depreciation or amortization schedule reflecting the expense, including the construction-in-progress subsidiary ledger;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) receipts for contractor fees; and

(vi) receipts for other costs associated with the capital expenditure.

(6) Invoices or contractor statements dated more than two years before the date the rebase request is received shall not be allowed. (Authorized by K.S.A. 2007 Supp. 75-7403 and 75-7412; implementing K.S.A. 2007 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008).

129-10-18. Per diem rates of reimbursement. (a) Per diem rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, using base-year cost information submitted by the provider and retained for cost auditing and analysis.

(A) The base year utilized for cost information shall be reestablished at least once every seven years.

(B) A factor for inflation may be applied to the base-year cost information.

(C) For each provider currently in new enrollment, reenrollment, or change of ownership status, the base year shall be determined in accordance with subsections (c), (d), and (e), respectively.

(2) Per diem rates shall be limited by cost centers, except where there are special level-of-care facilities approved by the United States department of health and human services. The upper payment limits shall be determined by the median in each cost center plus a percentage of the median, using base-year cost information. The percentage factor applied to the median shall be determined by the agency.

(A) The cost centers shall be as follows:

(i) Operating;

(ii) indirect health care; and

(iii) direct health care.

(B) The property component shall consist of the real and personal property fee as specified in K.A.R. 129-10-25.

(C) The upper payment limit for the direct health care cost center shall be a statewide base limit calculated on each facility's base-year costs adjusted for case mix.

(i) A facility-specific, direct health care cost center upper payment limit shall be calculated by adjusting the statewide base limit by that facility's average case mix index.

(ii) Resident assessments used to determine additional reimbursement for ventilator-dependent residents shall be excluded from the calculation of the facility's average case mix index.

(3) Each provider shall receive an annual per diem rate to become effective July 1 and, if there are any changes in the facility's average medicaid case mix index, an adjusted per diem rate to become effective January 1.

(4) Resident assessments that cannot be classified shall be assigned to the lowest case mix index.

(5) To establish a per diem rate for each provider, a factor for incentive may be added to the allowable per diem cost.

(6)(A) Resident days shall be determined from census information corresponding to the base-year cost information submitted by the provider.

(B) The total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates in the direct health care cost center. The

total number of resident days shall be used to calculate the per diem costs used to determine the upper payment limit and rates for food and utilities in the indirect health care cost center.

(C) For homes with more than 60 beds, the number of resident days used to calculate the upper payment limits and rates in the operating cost center and indirect health care cost center, less food and utilities, shall be subject to an 85 percent minimum occupancy requirement based on the following:

(i) Each provider that has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period, as specified in K.A.R. 129-10-17, shall have the number of resident days calculated at the minimum occupancy of 85 percent.

(ii) The 85 percent minimum occupancy requirement shall be applied to the number of resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider, unless the provider is allowed to file a projected cost report.

(iii) The minimum occupancy rate shall be determined by multiplying the total number of licensed beds by 85 percent. In order to participate in the Kansas medical assistance program, each nursing facility provider shall obtain proper certification for all licensed beds.

(iv) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period, as specified in K.A.R. 129-10-17, used in the rate computation.

(7) Each provider shall be given a detailed listing of the computation of the rate

determined for the provider's facility.

(8) The effective date of the rate for existing providers shall be in accordance with K.A.R. 129-10-19.

(b) Per diem rate limitations based on comparable service private-pay charges.

(1) Rates of reimbursement shall not be limited by private-pay charges.

(2) The agency shall maintain a registry of private-pay per diem rates submitted by providers.

(A) Each provider shall notify the agency of any change in the private-pay rate and the effective date of that change so that the registry can be updated.

(i) Private-pay rate information submitted with the cost reports shall not constitute notification and shall not be acceptable.

(ii) Providers may send private-pay rate notices by certified mail so that there is documentation of receipt by the agency.

(B) The private-pay rate registry shall be updated based on the notification from the providers.

(C) The effective date of the private-pay rate in the registry shall be the later of the effective date of the private-pay rate or the first day of the following month in which complete documentation of the private-pay rate is received by the agency.

(i) If the effective date of the private-pay rate is other than the first day of the month,

the effective date in the registry shall be the first day of the closest month. If the effective date is after the 15th, the effective date in the register shall be the first day of the following month.

(ii) For new facilities or new providers coming into the medicaid program, the effective date of the private-pay rate shall be the date on which certification is issued.

(3) The average private-pay rate for comparable services shall be included in the registry. The average private-pay rate may consist of the following variables:

(A) Room rate differentials. The weighted average private-pay rate for room differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in private rooms, semiprivate rooms, wards, and all other room types by the rate charged for each type of room. Sum the resulting products of each type of room. Divide the sum of the products by the total number of private-pay residents in all rooms. The result, or quotient, is the weighted average private-pay rate for room differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average private-pay rate if there are room rate differentials.

(iii) Failure to submit the documentation shall limit the private-pay rate in the registry to the semiprivate room rate.

(B) Level-of-care rate differentials. The weighted average private-pay rate for level-of-care differentials shall be determined as follows:

(i) Multiply the number of private-pay residents in each level of care by the rate they are charged to determine the product for each level of care. Sum the products for all of the levels of care. Divide the sum of the products by the total number of private-pay residents in all levels of care. The result, or quotient, is the weighted average private-pay rate for the level-of-care differentials.

(ii) Each provider shall submit documentation to show the calculation of the weighted average rate when there are level-of-care rate differentials.

(iii) Failure to submit the documentation may delay the effective date of the average private-pay rate in the registry until the complete documentation is received.

(C) Extra charges to private-pay residents for items and services may be included in the weighted average private-pay rate if the same items and services are allowable in the Kansas medical assistance program rate.

(i) Each provider shall submit documentation to show the calculation of the weighted average extra charges.

(ii) Failure to submit the documentation may delay the effective date of the weighted average private-pay rate in the registry until the complete documentation is received.

(4) The weighted average private-pay rate shall be based on what the provider receives from the resident. If the private-pay charges are consistently higher than what the provider receives from the residents for services, then the average private-pay rate for comparable services shall be based on what is actually received from the residents.

The weighted average private-pay rate shall be reduced by the amount of any discount received by the residents.

(5) The private-pay rate for medicare skilled beds shall not be included in the computation of the average private-pay rate for nursing facility services.

(6) When providers are notified of the effective date of the Kansas medical assistance program rate, the following procedures shall be followed:

(A) If the private-pay rate indicated on the agency register is lower, then the Kansas medical assistance program rate, beginning with its effective date, shall be calculated as follows:

(i) If the average medicaid case mix index is greater than the average private-pay case mix index, the Kansas medical assistance program rate shall be the lower of the private-pay rate adjusted to reflect the medicaid case mix or the calculated Kansas medical assistance rate.

(ii) If the average medicaid case mix index is less than or equal to the average private-pay case mix index, the Kansas medical assistance program rate shall be the average private-pay rate.

(B) Providers who are held to a lower private pay rate and subsequently notify the agency in writing of a different private-pay rate shall have the Kansas medical assistance program rate adjusted on the later of the first day of the month following the

date upon which complete private-pay rate documentation is received or the effective date of a new private-pay rate.

(c) Per diem rate for new construction or a new facility to the program.

(1) The per diem rate for any newly constructed nursing facility or a new facility to the Kansas medical assistance program shall be based on a projected cost report submitted in accordance with K.A.R. 129-10-17.

(2) The cost information from the projected cost report and the first historic cost report covering the projected cost report period shall be adjusted to the base-year period.

(3) The provider shall remain in new enrollment status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in new enrollment status.

(5) No rate shall be paid until a nursing facility financial and statistical report is received and processed to determine a rate.

(d) Change of provider.

(1) The payment rate for the first 24 months of operation shall be based on the base-year historical cost data of the previous owner or provider. If base-year data is not

available, data for the most recent calendar year available preceding the base-year period shall be adjusted to the base-year period and used to determine the rate. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, the 85 percent minimum occupancy requirement shall also be applied to the new provider's rate.

(2) Beginning with the first day of the 25th month of operation, the payment rate shall be based on the historical cost data for the first calendar year submitted by the new provider. The data shall be adjusted to the base-year period.

(3) The provider shall remain in change-of-provider status until the base year is reestablished. During this time, the adjusted cost data shall be used to determine all rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the adjusted cost data for each provider in change-of-provider status.

(e) Determination of the per diem rate for nursing facility providers reentering the medicaid program.

(1) The per diem rate for each provider reentering the medicaid program shall be determined from either of the following:

(A) A projected cost report if the provider has not actively participated in the

program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the base-year cost report filed with the agency or the most recent cost report filed preceding the base year, if the provider has actively participated in the program during the most recent 24 months.

(2) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), the cost data shall be adjusted to the base-year period.

(3) The provider shall remain under reenrollment status until the base year is reestablished. During this time, the cost data used to determine the initial rates shall be used to determine all subsequent rates for the provider.

(4) Each factor for inflation that is applied to cost data for established providers shall be applied to the cost data for providers in reenrollment status.

(5) If the per diem rate for a provider reentering the program is determined in accordance with paragraph (e)(1)(A), a settlement shall be made in accordance with subsection (f).

(f) Per diem rate errors.

(1) If the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider with an identified overpayment is no longer enrolled in the medicaid program, the settlement shall be recouped from a facility owned or operated by the same provider or that provider's corporation, unless other arrangements have been made to reimburse the agency. A net settlement may occur if a provider has more than one facility involved in settlements. In all cases, settlements shall be recouped within 12 months of the implementation of the corrected rates, or interest may be assessed.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit of the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the

provider wishes to have reviewed.

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report, as specified in K.A.R. 129-10-17, for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(g) Out-of-state providers.

(1) The per diem rate for out-of-state providers certified to participate in the Kansas medical assistance program shall be the rate approved by the agency.

(2) Each out-of-state provider shall obtain prior authorization by the agency.

(h) Reserve days. Reserve days as specified in K.A.R. 30-10-21 shall be paid at 67 percent of the Kansas medical assistance program per diem rate.

(i) Determination of rate for ventilator-dependent resident.

(1) The request for additional reimbursement for a ventilator-dependent resident shall be submitted to the agency in writing for prior approval. Each request

shall include the following:

(A) Sections A, I, and O in the nursing home comprehensive "minimum data set" ("MDS") of the centers for medicare and medicaid services (CMS);

(B) a current client assessment, referral, and evaluation (CARE) plan for the resident;

(C) a physician's order for ventilator use, including the frequency of ventilator use and a diagnosis that requires use of a ventilator; and

(D) a treatment administration record or respiratory therapy note showing the number of minutes used for the ventilator per shift.

(2) All of the following conditions shall be met in order for a resident to be considered ventilator-dependent:

(A) The resident is not able to breathe without mechanical ventilation.

(B) The resident uses a ventilator for life support 24 hours a day, seven days a week.

(C) The resident has a tracheostomy or endotracheal tube.

(3) The provider shall be reimbursed at the Kansas medical assistance program daily rate determined for the nursing facility plus an additional amount approved by the agency for the ventilator-dependent resident.

(4) No additional amount above that figured at the Kansas medical assistance program daily rate shall be allowed until the service has been authorized by the agency.

(5) The criteria shall be reviewed quarterly to determine if the resident is ventilator-dependent. If a resident is no longer ventilator-dependent, the provider shall not receive additional reimbursement beyond the Kansas medical assistance program daily rate determined for the facility.

(6) The additional reimbursement for the ventilator-dependent resident shall be offset to the cost center of benefit on the nursing facility financial and statistical report.

(j) Rate modification; secretary's discretion.

(1) Any of the requirements of this regulation may be waived by the secretary and a nursing facility's or nursing facility for mental health's per diem rate of reimbursement may be modified by the secretary if the secretary determines that both of the following conditions are met:

(A) Exceptional circumstances place residents of nursing facilities and nursing facilities for mental health in jeopardy of losing the availability of, or access to, "routine services and supplies," "ancillary services and other medically necessary services," "specialized mental health rehabilitation services," or "specialized services," as defined in K.A.R. 30-10-1a.

(B) The jeopardy can likely be avoided or reduced by modifying the per diem rate of reimbursement for a nursing facility or nursing facility for mental health.

(2) If the secretary exercises discretion pursuant to this subsection, the increase in the per diem rate of reimbursement shall not exceed the state average rate for reimbursement. (Authorized by K.S.A 2015 Supp. 65-1,254 and 75-7403; implementing K.S.A. 2015 Supp. 75-7405 and 75-7408; effective Sept. 19, 2008; amended; Feb 5, 2016.)

129-10-31. Responsibilities of, assessment of, and disbursements for the nursing facility quality care assessment program. (a) In addition to the terms defined K.S.A. 2013 Supp. 75-7435 and amendments thereto, the following terms shall have the meanings specified in this subsection, unless the context requires otherwise.

(1) "High medicaid volume skilled nursing care facility" means any facility that provided more than 25,000 days of nursing facility care to medicaid recipients during the most recent calendar year cost-reporting period.

(2) "Kansas homes and services for the aging," as used in K.S.A. 2013 Supp. 74-7435 and amendments thereto, means the leadingage Kansas.

(3) "Nursing facility quality care assessment program" means the determination, imposition, assessment, collection, and management of an annual assessment imposed on each licensed bed in a skilled nursing care facility required by K.S.A. 2013 Supp. 75-7435 and amendments thereto.

(4) "Skilled nursing care facility that is part of a continuing care retirement facility" means a provider who is certified as such by the Kansas insurance department before the start of the state's fiscal year in which the assessment process is occurring.

(5) "Small skilled nursing care facility" means any facility with fewer than 46 licensed nursing facility beds.

(b) The assessment shall be based on a state fiscal year. Each skilled nursing facility shall pay the annual assessment as follows:

(1) The assessment amount shall be $325 annually per licensed bed for the following:

(A) Each skilled nursing care facility that is part of a continuing care retirement facility;

(B) each small skilled nursing care facility; and

(C) each high medicaid volume skilled nursing care facility.

(2) The assessment amount for all skilled nursing care facilities other than those identified in paragraphs (c)(1)(A) through (C) shall be $1,950 annually per licensed bed.

(3) The assessment amount shall be paid accordingly to the method of payment designated by the secretary of Kansas department of health and environment. Any skilled nursing care facility may be allowed by the secretary of the Kansas department of health and environment to have an extension to complete the payment of the assessment, but no such extension shall exceed 90 days. (Authorized by and implementing K.S.A. 2013 Supp. 75-7435; effective February 18, 2011; amended December 27, 2013.)

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Rate Effective Date:	Cut-Off Dates for Quarterly CMI:
July 1	January 1 and April 1
January 1	July 1 and October 1

The resident listings will be mailed to providers prior to the dates the semi-annual case mix adjusted rates are determined. This will allow the providers time to review the resident listings and make corrections before they are notified of new rates. The cut off schedule may need to be modified in the event accurate resident listings and Medicaid CMI scores cannot be obtained from the MDS database.

4) Resident Days

Facilities with 60 beds or less:

For facilities with 60 beds or less, the allowable historic per diem costs for all cost centers are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data.

Facilities with more than 60 beds:

For facilities with more than 60 beds, the allowable historic per diem costs for the Direct Health Care cost center and for food and utilities in the Indirect Health Care cost center are determined by dividing the allowable resident related expenses by the actual resident days during the cost report period(s) used to establish the base cost data. The allowable historic per diem cost for the Operating and Indirect Health Care Cost Centers less food and utilities is subject to an 85% minimum occupancy rule. For these providers, the greater of the actual resident days for the cost report period(s) used to establish the base cost data or the 85% minimum occupancy based on the number of licensed bed days during the cost report period(s) used to establish the base cost data is used as the total resident days in the rate calculation for the Operating cost center and the Indirect Health Care cost center less food and utilities. All licensed beds are required to be certified to participate in the Medicaid program.

There are two exceptions to the 85% minimum occupancy rule for facilities with more than 60 beds. The first is that it does not apply to a provider who is allowed to file a projected cost report for an interim rate. Both the rates determined from the projected

Methods and Standards for Establishing Payment Rates
Nursing Facilities and Nursing Facilities-Mental Health

Narrative Explanation of Nursing Facility Reimbursement Formula

Level 2 Culture Change Achievement $1.00	This is a bridge level to acknowledge achievement in Level 1. Homes may receive this level at the same time they are working on other PEAK core areas at Level 1. Homes may receive this incentive for up to 3 years. If Level 3 is not achieved at the end of the third year, homes may start back at Level 0 or 1 depending on KDADS and KSU's recommendation.	Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.
Level 3 Person-Centered Care Home $2.00	Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a Level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.	Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year. Renewable bi-annually.
Level 4 Sustained Person-Centered Care Home $3.00	Homes earn person-centered care home award two consecutive years.	Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.

QUALITY AND EFFICIENCY INCENTIVE FACTOR EFFECTIVE 07/01/16

NF-MH ONLY

	QUALITY/EFFICIENCY OUTCOME	INCENTIVE POINTS
1	CMI adjusted staffing ratio >= 120% (3.56) of NF-MH median (2.97), or CMI adjusted staffing ratio between 110% (3.27) and 120%	2, or 1
2	Total occupancy <= 90%	1
3	Operating expenses < $18.60, 90% of NF-MH median, $20.67	1
4	Staff turnover rate <= 75th percentile, 39% Staff turnover rate <= 50th percentile, 61% Contracted labor < 10% of total direct health care labor costs	2, or 1
5	Staff retention >= 75th percentile, 74% Staff retention >= 50th percentile, 62%	2, or 1
	Total Incentive Points Available	8

Total Incentive Points:	Incentive Factor Per Diem:
Tier 1: 6-8 points	$7.50
Tier 2: 5 points	$5.00
Tier 3: 4 points	$2.50
Tier 4: 0-3 points	$0.00