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State/Territory Name: MO
State Plan Amendment (SPA) #: 19-0006
This file contains the following documents in the order listed:

1) Approval Letter
2) Summary Form (with 179-like data)
3) Approved SPA Pages

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

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

Financial Management Group

June 24, 2019

Dr. Steve Corsi, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, MO 65102

RE: Missouri Medicaid State Plan Amendment TN: 19-0006

Dear Dr. Corsi:

We have reviewed the proposed amendment to Attachment 4.19-D of your Medicaid State plan submitted under transmittal number (TN) 19-0006. Effective for dates of service beginning January 1, 2019, this amendment rebases per diem rates for nonstate-operated Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Per Diem rates will now be calculated from costs reported for fiscal year 2017. This amendment also adds clarifying language to the rate setting methodology and removes and/or replaces obsolete or duplicative language from the State plan.

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 19-0006 is approved effective January 1, 2019. We are enclosing the CMS-179 and the amended plan pages.

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: 19 – 0006

2. STATE: Missouri

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
January 1, 2019

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 Subpart C

7. FEDERAL BUDGET IMPACT
a. FFY 2019 $ 397,000
b. FFY 2020 $ 536,000

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19-D, Pages 174-204

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 4.19-D, Pages 174-223
Pages 205-223 are being deleted as a result of this amendment

10. SUBJECT OF AMENDMENT
This amendment provides for a rebasing of per diem rates for nonstate-operated Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID); clarifies the process for determining reimbursement rates; removes and/or replaces obsolete processes and language; and, combines and removes duplicative language.

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

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Steve Corsi, Psy. D.

14. TITLE
Director

15. DATE SUBMITTED
3/29/19

16. RETURN TO
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

18. DATE APPROVED
JUN 24 2019

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
JAN 01 2019

20. SIGNATURE OF REGIONAL OFFICIAL
[redacted]

21. TYPED NAME
Kristin Fan

22. TITLE
Director, FMG

23. REMARKS

FORM CMS-179 (07/92)

Instructions on Back

Prospective Reimbursement Plan for Nonstate-Operated
Facilities for ICF/IID Services

(1) Objectives. This plan establishes a payment for nonstate-operated intermediate care facility/for individuals with intellectual disabilities (ICF/IID) services.

(2) General Principles.

(A) The Missouri Medical Assistance Program shall reimburse qualified providers of ICF/IID services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate less any payments made by participants.

(B) Effective November 1, 1986, the Title XIX per-diem rate for all ICF/IID facilities participating on or after October 31, 1986, shall be the lower of—

1. The Medicare per diem rate, if applicable; or

2. The reimbursement rate as determined in accordance with this plan.

(C) This plan has an effective date of November 1, 1986, at which time prospective per diem rates shall be calculated for the remainder of the state's FY-87 and future fiscal years. Per- diem rates established by updating facilities' base years to FY-85 may be subject to retroactive and prospective adjustment based on audit of the facilities' new base year period.

(D) The Title XIX per diem rates as determined by this plan shall apply only to services furnished on or after November 1, 1986.

(E) All illustrations and examples provided throughout this plan are for illustration purposes only and are not meant to be actual calculations.

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the MO HealthNet program based upon the principles established in this plan. The allowability of cost areas, not specifically addressed in this plan, will be based upon criteria of the *Medicare Provider Reimbursement Manual* (HIM-15) and section (6) of this plan.

(B) Average private pay charge. The average private pay charge is the usual and customary charge for non-MO HealthNet patients determined by dividing total non-MO HealthNet days of care into total revenue collected for the same service that is included in the MO HealthNet per-diem rate, excluding negotiated payment methodologies with the Veterans Administration and the Missouri Department of Mental Health.

(C) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(D) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(E) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(F) Effective date.

1. The plan effective date shall be November 1, 1986.

(G) ICF/IID. Nonstate-operated facilities certified to provide intermediate care for individuals with intellectual disabilities under the Title XIX program.

(H) Medicare rate. This is the allowable cost of care permitted by Medicare standards and principles of reimbursement.

(I) New construction. Newly built facilities or parts, for which an approved Certificate of Need (CON) or applicable waivers were obtained and which were newly completed and operational on or after November 1, 1986.

(J) New owners. Original owners of new construction.

(K) Providers. A provider under the Prospective Reimbursement Plan is a nonstate-operated ICF/IID facility with a valid participation agreement, in effect on or after October 31, 1986, with the Missouri Department of Social Services for the purpose of providing long-term care (LTC) services to Title XIX-eligible participants. Facilities certified to provide intermediate care services to individuals with intellectual disabilities under the Title XIX program may be offered a MO HealthNet participation agreement on or after January 1, 1990, only if 1) the facility has no more than fifteen (15) beds for individuals with intellectual disabilities, and 2) there is no other licensed residential living facility for individuals with intellectual disabilities within a radius of one-half (1/2) mile of the facility seeking participation in the MO HealthNet program.

(L) Reasonable and adequate reimbursement. Reimbursement levels which meet the needs of an efficiently and economically operated facility and which in no case exceed normal market costs.

(M) Related parties. Parties are related when—

1. An individual or group, regardless of the business structure of either, where, through their activities, one (1) individual's or group's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in the dealings;

2. One (1) or more persons have an ownership or controlling interest in a party, and the person(s) or one (1) or more relatives of the person(s) has an ownership or controlling interest in the other party. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm, or insurance company unless the entity, directly or through a subsidiary, operates a facility; or

3. As used in section (3), the following terms mean:

   A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

   B. Ownership interest means the possession of equity in the capital, in the stock, or in the profits of an entity;

   C. Ownership or controlling interest is when a person or corporation(s)—

      (I) Has an ownership interest totalling five percent (5%) or more in an entity;

      (II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by an entity, if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from the obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership;

D. Relative means persons related by blood or marriage to the fourth degree of consanguinity; and

E. Entity means any person, corporation, partnership, or association.

(N) Rural. Those counties which are not defined as urban.

(O) Urban. The urban counties are standard metropolitan statistical areas including Andrew, Boone, Buchanan, Cass, Christian, Clay, Franklin, Greene, Jackson, Jasper, Jefferson, Newton, Platte, Ray, St. Charles, St. Louis, and St. Louis City.

(4) ICF/IID Rate Computation. Except in accordance with other provisions of this rule, the provisions of this section shall apply to all providers of ICF/IID services certified to participate in Missouri's MO HealthNet program. Rate determination shall be based on reasonable and adequate reimbursement levels for allowable cost items described in this rule which are related to ordinary and necessary care for the level-of-care provided for an efficiently and economically operated facility. All providers shall submit documentation of expenses for allowable cost areas. The department shall have authority to require those uniform accounting and reporting procedures and forms as it deems necessary. A reasonable and adequate reimbursement in each allowable cost area will be determined.

(A) Prospective Reimbursement Rate Determination through December 31, 2018.

1. The Title XIX prospective per diem reimbursement rate for the remainder of state Fiscal Year 1987 shall be the facility's per diem reimbursement payment rate in effect on October 31, 1986, as adjusted by updating the facility's allowable base year to its 1985 fiscal year. Each facility's per diem costs as reported on its Fiscal Year 1985 Title XIX cost report will be determined in accordance with the principles set forth in this rule. If a facility has not filed a 1985 fiscal year cost report, the most current cost report on file with the department will be used to set its per diem rate. Facilities with less than a full twelve- (12) month 1985 fiscal year will not have their base year rates updated.

2. For state FY-88 and dates of service beginning July 1, 1987, the negotiated trend factor shall be equal to two percent (2%) to be applied in the following manner: Two percent (2%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1987, shall be added to each facility's rate.

3. For state FY-89 and dates of service beginning January 1, 1989, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1988, shall be added to each facility's rate.

4. For state FY-91 and dates of service beginning July 1, 1990, the negotiated trend factor shall be equal to one percent (1%) to be applied in the following manner: One percent (1%) of the average per diem rate paid to both state- and nonstate-operated ICF/IID facilities on June 1, 1990, shall be added to each facility's rate.

5. Prospective payment adjustment (PPA). A FY92 PPA will be provided prior to the end of the state fiscal year for nonstate-operated ICF/IID facilities with a current provider agreement on file with the MO HealthNet Division as of October 1, 1991.

   A. For providers which qualify, the PPA shall be the lesser of -

      (I) The provider's facility peer group factor (FPGF) times the projected patient days (PPD) covered by the adjustment year times the prospective payment adjustment factor (PPAF) times the nonstate-operated intermediate care facility for individuals with intellectual disabilities ceiling (ICFIIDC) on October 1, 1991 (FPGF × PPD × PPAF × ICFIIDC). For example: A provider having nine hundred twenty (920) paid days for the period May 1991 to July 1991 out of a total paid days for this same period of twenty-eight thousand five hundred sixty-one (28,561) represents an FPGF of three and twenty-two hundredths percent (3.22%). So using the FPGF of 3.22% × 114,244 × 24.5% × $156.01 = $140,659; or

      (II) The provider FPGF times one hundred forty-five percent (145%) of the amount credited to the intermediate care revenue collection center (ICRCC) of the State Title XIX Fund (STF) for the period October 1, 1991 through December 31, 1991.

   B. FPGF—is determined by using each ICF/IID facility's paid days for the service dates in May 1991 through July 1991 as of September 20, 1991, divided by the sum of the paid days for the same service dates for all provider's qualifying as of the determination date of October 16, 1991.

   C. ICFIIDC—is one hundred fifty-six dollars and one cent ($156.01) on October 1, 1991.

   D. PPAF—is equal to twenty-four and five-tenths percent (24.5%) for fiscal year 1992 which includes an adjustment for economic trends.

E. PPD—is the projection of one hundred fourteen thousand two hundred forty-four (114,244) patient days made on October 1, 1991, for the adjustment year.

6. FY-92 trend factor and Workers' Compensation. All facilities with either an interim rate or a prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of eight dollars and eighty-six cents ($8.86) per patient day related to the continuation of the FY-92 trend factor and the Workers' Compensation adjustment. This adjustment is equal to seven and one-half percent (7.5%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities.

7. FY-93 negotiated trend factor. All facilities with either an interim rate or prospective per diem rate in effect on September 1, 1992, shall be granted an increase to their per diem rate effective September 1, 1992, of one dollar and sixty-six cents ($1.66) per patient day for the negotiated trend factor. This adjustment is equal to one and four-tenths percent (1.4%) of the March 1992 weighted average per diem rate of one hundred eighteen dollars and fourteen cents ($118.14) for all nonstate-operated ICF/IID facilities.

8. FY-96 negotiated trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning January 1, 1996, of six dollars and seven cents ($6.07) per patient day for the negotiated trend factor. This adjustment is equal to four and six-tenths percent (4.6%) of the weighted average per diem rates paid to nonstate-operated ICF/IID facilities on June 1, 1995, of one hundred and thirty-one dollars and ninety-three cents ($131.93).

9. State FY-99 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1998, of four dollars and forty-seven cents ($4.47) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 1998, of one hundred forty-eight dollars and ninety-nine cents ($148.99).

10. State FY-2000 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 1999, of four dollars and sixty-three cents ($4.63) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 1999, of one hundred fifty-four dollars and forty-three cents ($154.43). This increase shall only be used for increases for the salaries and fringe benefits for direct care staff and their immediate supervisors.

11. State FY-2001 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates effective for dates of service beginning July 1, 2000, of four dollars and eighty-one cents ($4.81) per patient day for the trend factor. This adjustment is equal to three percent (3%) of the weighted average per diem rate paid to nonstate-operated ICF/IID facilities on April 30, 2000, of one hundred sixty dollars and twenty-three cents ($160.23). This increase shall only be used for increases for salaries and fringe benefits for direct care staff and their immediate supervisors.

12. State FY-2007 trend factor. All nonstate-operated ICF/IID facilities shall be granted an increase of seven percent (7%) to their per diem rates effective for dates of service billed for state fiscal year 2007 and thereafter. This adjustment is equal to seven percent (7%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2006.

13. State FY-2008 trend factor. Effective for dates of service beginning July 1, 2007, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2007.

14. State FY-2009 trend factor. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008.

15. State FY-2009 catch up increase. Effective for dates of service beginning July 1, 2008, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of thirteen and ninety-five hundredths percent (13.95%). This adjustment is equal to thirteen and ninety-five hundredths percent (13.95%) of the per diem rate paid to nonstate-operated ICF/IID facilities on June 30, 2008. This increase is intended to provide compensation to providers for the years where no trend factor was given. The catch up increase was based on the CMS PPS Skilled Nursing Facility Input Price Index (four- (4-) quarter moving average).

16. State FY-2012 trend factor. Effective for dates of service beginning October 1, 2011, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one and four tenths percent (1.4%) for the trend factor. This adjustment is equal to one and four tenths percent (1.4%) of the per diem rate paid to nonstate-operated ICF/IID facilities on September 30, 2011.

17. State FY-2014 trend factor. Effective for dates of service beginning January 1, 2014, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of three percent (3%) for the trend factor. This adjustment is equal to three percent (3%) of the per diem rate paid to nonstate-operated ICF/IID facilities on December 31, 2013.

18. State FY-2016 trend factor. Effective for dates of service beginning February 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of one percent (1%) for the trend factor. This adjustment is equal to one percent (1%) of the per diem rate paid to nonstate-operated ICF/IID facilities on January 31, 2016.

19. State FY-2017 trend factor. Effective for dates of service beginning September 1, 2016, all nonstate-operated ICF/IID facilities shall be granted an increase to their per diem rates of two percent (2%) for the trend factor. This adjustment is equal to two percent (2%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2016.

20. State FY-2018 per diem adjustment. Effective for dates of service beginning September 1, 2017, all nonstate-operated ICF/IID facilities shall be subject to a decrease to their per diem rates of two and eighty-two hundredths percent (2.82%). This adjustment is equal to two and eighty-two hundredths percent (2.82%) of the per diem rate paid to nonstate-operated ICF/IID facilities on August 31, 2017.

(B) Per Diem Rate Calculation Effective for Dates of Service Beginning January 1, 2019. Effective for dates of service beginning January 1, 2019, nonstate-operated ICF/IID per diem rates shall be rebased using the facilities' 2017 fiscal year end cost reports. The rebased rates are contingent upon approval of the state plan amendment by the Centers for Medicare and Medicaid Services.

1. Prospective Rate Calculation.

A. Each nonstate-operated ICF/IID shall have its prospective rate recalculated based on their 2017 fiscal year end cost report using the same principles and methodology as detailed throughout sections (1) – (13) of this plan.

(I) The costs from the 2017 fiscal year end cost reports shall be trended using the indices from the most recent publication of the Healthcare Cost Review available to the division using the "CMS Nursing Home without Capital Market Basket" table. The costs shall be trended using the four quarter moving average. The costs shall be trended for the years following the cost report year, up to and including the state fiscal year corresponding to the effective date of the rates. For SFY 2019, the trends are as follows:

(a) 2018=3.025%
(b) 2019=2.65%

(II) If a facility's total calculated per diem set forth in this section is less than the facility's current rate, the facility shall continue to receive its current rate.

(III) The division will use the FY 2017 cost report to determine the ICF/IID prospective rate, set forth as follows:

(a) Total Routine Service Cost. Total routine service cost includes patient care, ancillary, dietary, laundry, housekeeping, plant operations, and administration. Each ICF/IID's Title XIX Routine Service Cost per diem shall be calculated as follows:

I. The total routine service costs as reported on the cost report shall be adjusted for minimum utilization, if applicable, trended to the current state fiscal year, and divided by the total patient days to determine the per diem. The minimum utilization adjustment will be determined by applying the unused capacity percent to the sum of the laundry, housekeeping, plant operations, and administration expenses. The following is an illustration of how this item (4)(B)1.A.(III)(a)I. is calculated:

Licensed/Certified Bed Days (9 beds x 365 days)	3,285
Total Patient Days	2,900
Percent Occupied (2,900/3,285)	88%
Bed Days @ Minimum Occupancy of 90% (3,285 x 90%)	2,957
Unused Capacity (90% of Bed Days Less Total Patient Days)	57
Unused Capacity Percent for Minimum Utilization Adjustment (Unused Capacity / 90% of Bed Days)	1.93%
Minimum Utilization Days for Return on Owner's Equity (Greater of 90% of Bed Days or Total Patient Days)	2,957
* Minimum Utilization Adjustment	
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Expense	$224,000
Unused Capacity Percent	1.93%
Minimum Utilization Adjustment (Unused Capacity Percent x Total Expense)	$4,323

Patient Care	$400,000
Ancillary	$10,000
Dietary	$25,000
Laundry	$5,000
Housekeeping	$8,000
Plant Operations	$46,000
Administration	$165,000
Total Routine Service Cost	$659,000
Less: Minimum Utilization Adjustment *	($4,323)
Routine Service Cost, Adjusted for Minimum Utilization	$654,677
SFY 2018 Trend	3.025%
SFY 2019 Trend	2.65%
Trended Routine Service Cost	$692,355
Total Patient Days	2,900
Routine Service Cost Per Diem	$238.74

(b) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The SFY 2019 ICF/IID FRA provider assessment as determined in accordance with 9 CSR 10-31.030 is divided by total patient days to determine the ICF/IID FRA per diem.

I. The following is an illustration of how the ICF/IID FRA assessment is calculated:

SFY 2019 ICF/IID FRA Assessment	$40,000
Total Patient Days	2,900
ICF/IID FRA Per Diem	$13.79

(c) Return on Equity. An owner's net equity is comprised of investment capital and working capital as indicated in subsection (6)(S). Each ICF/IID's Return on Equity per diem is calculated as follows:

I. Investment Capital. Investment capital includes the investment in building, property and equipment (cost of land, mortgage payments toward principle and equipment purchase less the accumulated depreciation).

II. Working Capital. Working capital represents the amount of capital which is required to insure proper operation of the facility and shall be calculated as 1.1 months of the total expenses less depreciation.

III. The total net equity shall be multiplied by the rate of return as set forth in Section (6)(S) to determine the return on equity. The return on equity is subject to the minimum occupancy percent of 90% in determining the per diem.

IV. The following is an illustration of how this item (4)(B)1.A.(III)(c) is calculated:

Investment Capital

	Equipment	Building	Total
Cost	$130,000	$300,000	$430,000
Less: Prior Years Depreciation	($120,000)	($225,000)	($345,000)
Less: Current Year Depreciation	($2,400)	($8,500)	($10,900)
Total Investment Capital	$7,600	$66,500	$74,100

Working Capital	
Total Expenses	$659,000
Less: Current Year Depreciation Expense	($10,900)
	$648,100
Divided by 12 Months	12
	$54,008
Times 1.1 Months	1.1
Total Working Capital	$59,409

Net Equity (Investment Capital + Working Capital)	$133,509
Rate of Return	5.125%
Return on Equity	$6,842
Minimum Utilization Days	2,957
Return on Equity Per Diem	$2.31

(d) Rebased Per-Diem Rate. The total calculated Per-Diem is the sum of the Routine Service Cost per diem, the ICF/IID FRA per diem and the Return on Equity per diem. To determine the rebased per diem rate, the total calculated per diem is compared to the current per diem rate and the facility will be held harmless if the total calculated per diem is less than the current per diem rate (i.e., if the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem).

Routine Service Cost per diem	$238.74
ICF/IID FRA per diem	$13.79
Return on Equity per diem	$2.31
Total Calculated Per Diem	$254.84

Current Per Diem Rate $200.00

Rebased Per Diem Rate $254.84

(If the total calculated per diem is less than the current per diem rate, the facility would receive the current per diem rate)

2. Interim Rate Calculation.

A. In the case of a newly certified facility where a valid Title XIX participation agreement has been executed, a request for an interim rate must be submitted in writing to the MO HealthNet Division.

(I) The interim rate shall be determined based on the projected estimated operating costs. The facility's request must specifically and clearly identify the interim rate and be supported by complete, accurate, and documented records satisfactory to the single state agency. Documentation submitted must include a budget of the projected estimated operating costs. Other documentation may also be required to be submitted upon the request of the division.

(II) The establishment of the prospective rate for all new construction facility providers shall be based on the second full facility fiscal year cost report (i.e., rate setting cost report) prepared in accordance with the principles of this plan. This cost report shall be based on actual operating costs and shall be prepared and submitted in accordance with the reporting requirements in section (7).

(III) Prior to establishment of a prospective rate for newly certified facility providers, the cost reports may be subject to an on-site audit by the Department of Social Services or authorized representative to determine the facility's actual allowable costs. Allowability of costs will be determined as described in subsection (3)(A) of this plan.

(IV) The cost report, audited or unaudited, will be reviewed by the MO HealthNet Division, and a prospective reimbursement rate shall be determined on the allowable per diem cost as set forth in section (4). The prospective reimbursement rate shall be effective on the first day of the facility's rate setting cost report and payment adjustments shall be made for claims paid at the interim rate.

3. Adjustments to rates. The prospectively determined reimbursement rate may be adjusted only under the following conditions:

A. When information contained in a facility's cost report is found to be fraudulent, misrepresented, or inaccurate, the facility's reimbursement rate may be reduced, both retroactively and prospectively, if the fraudulent, misrepresented, or inaccurate information as originally reported resulted in establishment of a higher reimbursement rate than the facility would have received in the absence of this information. No decision by the MO HealthNet agency to impose a rate adjustment in the case of fraudulent, misrepresented, or inaccurate information in any way shall affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rule. The fact that fraudulent, misrepresented, or inaccurate information reported did not result in establishment of a higher reimbursement rate than the facility would have received in the absence of the information also does not affect the MO HealthNet agency's ability to impose any sanctions authorized by statute or rules;

B. Extraordinary circumstances. A participating facility that has a prospective rate may request an adjustment to its prospective rate due to extraordinary circumstances. This request should be submitted in writing to the division within one (1) year of the occurrence of the extraordinary circumstance. The request should clearly and specifically identify the conditions for which the rate adjustment is sought. The dollar amount of the requested rate adjustment should be supported by complete, accurate, and documented records satisfactory to the division. If the division makes a written request for additional information and the facility does not comply within ninety (90) days of the request for additional information, the division shall consider the request withdrawn. Requests for rate adjustments that have been withdrawn by the facility or are considered withdrawn because of failure to supply requested information may be resubmitted once for the requested rate adjustment. In the case of a rate adjustment request that has been withdrawn and then resubmitted, the effective date shall be the first day of the month in which the resubmitted request was made providing that it was made prior to the tenth day of the month. If the resubmitted request is not filed by the tenth of the month, rate adjustments shall be effective the first day of the following month. Conditions for an extraordinary circumstance are as follows:

(I) When the provider can show that it incurred higher costs due to circumstances beyond its control, and the circumstances are not experienced by the nursing home or ICF/IID industry in general, and the costs have a substantial cost effect;

(II) Extraordinary circumstances, beyond the reasonable control of the ICF/IID and is not a product or result of the negligence or malfeasance of the ICF/IID, include:

(a) Unavoidable acts of nature are natural wildfire, earthquakes, hurricane, tornado, lightning, flooding, or other natural disasters for which no one can be held responsible, that are not covered by insurance and that occur in a federally declared disaster area; or

(b) Vandalism, civil disorder, or both that are not covered by insurance; or

(c) Replacement of capital depreciable items not built into existing rates that are the result of circumstances not related to normal wear and tear or upgrading of existing system.

C. When an adjustment is based on an Administrative Hearing Commission or court decision.

D. New, expanded, or terminated services may be subject to rate review.

E. Disallowance of federal financial participation.

F. The following will not be subject to review:

(I) The negotiated trend factor;

(II) The use of prospective reimbursement rate; and

(III) The cost base for the per diem rates except as specified in this plan.

(5) Covered Services and Supplies.

(A) ICF/IID services and supplies covered by the per diem reimbursement rate under this plan, and which must be provided, as required by federal or state law or rule and include, among other services, the regular room, dietary and nursing services, or any other services that are required for standards of participation or certification. Also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

1. All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service, and enemas;

2. Items which are furnished routinely and relatively uniformly to all participants, for example, gowns, water pitchers, soap, basins, and bed pans;

3. Items such as alcohol, applicators, cotton balls, bandaids, and tongue depressors;

4. All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners, and nonlegend vitamins. Any nonlegend drug in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per diem rate;

5. Items which are utilized by individual participants but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable, nondepreciable medical equipment;

6. Additional items as specified in the appendix to this plan when required by the patient;

7. Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, including dietary supplements written as a prescription item by a physician;

8. All laundry services except personal laundry which is a noncovered service;

9. All general personal care services which are furnished routinely and relatively uniformly to all recipients for their personal cleanliness and appearance shall be covered services, for example, necessary clipping and cleaning of fingernails and toenails, basic hair care, shampoos, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the patient or his/her responsible party for this type of personal service;

10. All consultative services as required by state or federal law or regulation or for proper operation by the provider. Contracts for the purchase of these services must accompany the provider cost report. Failure to do so will result in the penalties specified in section (9) of this plan;

11. Semiprivate room and board and private room and board when necessary to isolate a participant due to a medical or social condition, such as contagious infection, irrational loud speech, and the like. Unless a private room is necessary due to a medical or social condition, a private room is a noncovered service, and a MO HealthNet participant or responsible party may therefore pay the difference between a facility's semiprivate charge and its charge for a private room. MO HealthNet participants may not be placed in private rooms and charged any additional amount above the facility's MO HealthNet per diem unless the participant or responsible party in writing specifically requests a private room prior to placement in a private room and acknowledges that an additional amount not payable by MO HealthNet will be charged for a private room;

12. Twelve (12) days per any period of six (6) consecutive months during which a participant is on a temporary leave of absence from the facility. Temporary leave of absence days must be specifically provided for in the participant's plan of care. Periods of time during which a participant is away from the facility because s/he is visiting a friend or relative are considered temporary leaves of absence; and

13. Days when participants are away from the facility overnight on facility-sponsored group trips under the continuing supervision and care of facility personnel.

(6) Allowable Cost Areas.

(A) Compensation of Owners.

1. Allowance of compensation of services of owners shall be an allowable cost area, provided the services are actually performed and are necessary services.

2. Compensation shall mean the total benefit, within the limitations set forth in this plan, by the owner of the services s/he renders to the facility including direct payments for managerial, administrative, professional, and other services, amounts paid by the provider for the personal benefit of the owner, the cost of assets and services which the owner receives from the provider, and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described.

3. Reasonableness of compensation may be determined by reference to or in comparison with compensation paid for comparable institutions or it may be determined by other appropriate means such as the *Medicare and Medicaid Provider Reimbursement Manual* (HIM-15) or by other means.

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility, had the provider not rendered these services, then employment of another person(s) to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this plan.

(C) Depreciation.

1. An appropriate allowance for depreciation on buildings, furnishings, and equipment which are part of the operation and sound conduct of the provider's business is an allowable cost item. Finder's fees are not an allowable cost item.

2. The depreciation must be identifiable and recorded in the provider's accounting records, based on the basis of the asset and prorated over the estimated useful life of the asset using the straight-line method of depreciation from the date initially put into service.

3. The basis of assets at the time placed in service shall be the lower of—

   A. The book value of the provider;

   B. Fair market value at the time of acquisition;

   C. The recognized Internal Revenue Service (IRS) tax basis; and

   D. In the case of the change in ownership, the cost basis of acquired assets of the owner of record on or after July 18, 1984, as of the effective date of the change of ownership; or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

4. The basis of donated assets will be allowed to the extent of recognition of income resulting from the donation of the asset. Should a dispute arise between a provider and the Department of Social Services as to the fair market value at the time of acquisition of a depreciable asset and an appraisal by a third party is required, the appraisal cost will be shared proportionately by the MO HealthNet program and the facility in ratio to MO HealthNet participant reimbursable patient days to total patient days.

5. Allowable methods of depreciation shall be limited to the straight-line method. The depreciation method used for an asset under the MO HealthNet program need not correspond to the method used by a provider for non-MO HealthNet purposes; however, useful life shall be in accordance with the American Hospital Association's Guidelines. Component part depreciation is optional and allowable under this plan.

6. Historical cost is the cost incurred by the provider in acquiring the asset and preparing it for use except as provided in this rule. Usually, historical cost includes costs that would be capitalized under generally accepted accounting principles. For example, in addition to the purchase price, historical cost would include architectural fees and related legal fees. Where a provider has elected, for federal income tax purposes, to expense certain items such as interest and taxes during construction, the historical cost basis for MO HealthNet depreciation purposes may include the amount of these expensed items. However, where a provider did not capitalize these costs and has written off the costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program. For Title XIX purposes and this rule, any asset costing less than five hundred dollars ($500) or having a useful life of one (1) year or less, may be expensed and not capitalized at the option of the provider, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program.

7. When an asset is acquired by trading in an existing asset, the cost basis of the new asset shall be the sum of the undepreciated cost basis of the traded asset plus the cash paid.

8. For the purpose of determining allowance for depreciation, the cost basis of the asset shall be as prescribed in paragraph (6)(C)3.

9. Capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a provider's bed capacity shall not be allowed in the program or depreciation base if these capital expenditures fail to comply with any other federal or state law or regulation, such as Certificate of Need (CON).

10. Amortization of leasehold rights and related interest and finance costs shall not be allowable costs under this plan.

(D) Interest and Finance Costs.

1. Necessary and proper interest on both current and capital indebtedness shall be an allowable cost item excluding finder's fees.

2. Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. This is usually for those purposes as working capital for normal operating expenses. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes, such as the acquisition of facilities and capital improvements, and this indebtedness must be amortized over the life of the loan.

3. Interest may be included in finance charges imposed by some lending institutions or it may be a prepaid cost or discount in transactions with those lenders who collect the full interest charges when funds are borrowed.

4. To be an allowable cost item, interest (including finance charges, prepaid costs, and discounts) must be supported by evidence of an agreement that funds were borrowed and that payment of interest and repayment of the funds are required, identifiable in the provider's accounting records, relating to the reporting period in which the costs are claims, and necessary and proper for the operation, maintenance, or acquisition of the provider's facilities.

5. Necessary means that the interest be incurred for a loan made to satisfy a financial need of the provider and for a purpose related to participant care. Loans which result in excess funds or investments are not considered necessary.

6. Proper means that the interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made, and provided further the department shall not reimburse for interest and finance charges any amount in excess of the prime rate current at the time the loan was obtained.

7. Interest on loans to providers by proprietors, partners, and any stockholders shall not be an allowable cost item because the loans shall be treated as invested capital and included in the computation of an allowable return on owner's net equity. If a facility operated by a religious order borrows from the order, interest paid to the order shall be an allowable cost.

8. If loans for capital indebtedness exceed the asset cost basis as defined in subsection (6)(C) of this plan, the interest associated with the portion of the loan(s) which exceed the asset cost basis as defined in subsection (6)(C) of this plan shall not be allowable.

9. Income from a provider's qualified retirement fund shall be excluded in consideration of the per diem rate.

10. A provider shall amortize finance charges, prepaid interest, and discount over the period of the loan ratably or by means of the constant rate of interest method on the unpaid balance.

11. Usual and customary costs, excluding finder's fees, incurred to obtain loans shall be treated as interest expense and shall be allowable costs over the loan period ratably or by means of the constant interest applied method.

12. Usual and customary costs shall be limited to the lender's title and recording fees, appraisal fees, legal fees, escrow fees, and closing costs.

13. Interest expense resultant from capital expenditures for building construction or for renovation costs which are in excess of one hundred fifty thousand dollars ($150,000) and which cause an increase in a bed capacity by the provider shall not be an allowable cost item if the capital expenditure fails to comply with other federal or state law or rules such as CON.

(E) Rental and Leases.

1. Rental and leases of land, buildings, furnishings, and equipment are allowable cost areas provided that the rented items are necessary and not in essence a purchase of those assets. Finder's fees are not an allowable cost item.

2. Necessary rental and lease items are those which are pertinent to the economical operation of the provider.

3. In the case of related parties, rental and lease amounts cannot exceed the lesser of those which are actually paid or the costs to the related party.

4. Determination of reasonable and adequate reimbursement for rental and amounts, except in the case of related parties which is subject to other provisions of this plan, may require affidavits of competent, impartial experts who are familiar with the current rentals and leases.

5. The test of necessary costs shall take into account the agreement between the owner and the tenant regarding the payment of related property costs.

6. Leases subject to CON approval must have that approval before a rate is determined.

7. If rent or lease costs increase solely as a result of change in ownership, the resulting increase which exceeds the allowable capital cost of the owner of record as of July 18, 1984, or in the case of a facility which entered the program after July 18, 1984, the owner at the time of the initial entry into the MO HealthNet program, shall be a nonallowable cost.

(F) Taxes. Taxes levied on or incurred by providers shall be allowable cost areas with the exceptions of the following items:

1. Federal, state, or local income and excess profit taxes including any interest and penalties paid;

2. Taxes in connection with financing, refinancing, or refunding operations, such as taxes on the issuance of bond, property transfer, issuance of transfer of stocks;

3. Taxes for which exemptions are available to the provider;

4. Special assessments on land which represent capital improvements. These costs shall be capitalized and depreciated over the period during which the assessment is scheduled to be paid;

5. Taxes on property which are not a part of the operation of the provider;

6. Taxes which are levied against a resident and collected and remitted by the provider; and

7. Self-employment Federal Insurance Contributions Act (FICA) taxes applicable to individual proprietors, partners, or members of a joint venture to the extent the taxes exceed the amount which would have been paid by the provider on the allowable compensation of the persons had the provider organization been an incorporated rather than unincorporated entity.

(G) Issuance of Revenue Bond and Tax Levies by District and County Facilities. Those nursing home districts and county facilities whose funding is through the issuance of revenue bonds, that interest which is paid per the revenue bond will be an allowable cost item. Depreciation on the plant and equipment of these facilities also shall be an allowable cost item. Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(H) Value of Services of Employees.

1. Except as provided for in this rule, the value of services performed by employees in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the supplying organization.

2. Services rendered by volunteers, such as those affiliated with the American Red Cross, hospital guilds, auxiliaries, private individuals, and similar organizations, shall not be included as an allowable cost area, as the services have traditionally been rendered on a purely volunteer basis without expectation of any form of reimbursement by the organization through which the service is rendered or by the person rendering the service.

3. Services by priests, ministers, rabbis, and similar type professionals shall be an allowable cost area; provided, that the services are not of a religious nature. An example of an allowable cost area under this section would be a necessary administrative function performed by a clergyman. The state will not recognize building costs on space set aside primarily for professionals providing any religious function. Costs for wardrobe and similar items likewise are considered nonallowable.

(I) Fringe Benefits.

1. Life insurance.

A. Types of insurance which are not considered an allowable cost area; premiums related to insurance on the lives of officers and key employees are not allowable cost areas under the following circumstances:

(I) Where, upon the death of an insured officer or key employee, the insurance proceeds are payable directly to the provider. In this case, the provider is a direct beneficiary. Insurance of this type is referred to as key-man insurance; and

(II) Where insurance on the lives of officers is voluntarily taken out as part of a mortgage loan agreement entered into for building construction and, upon the death of an insured officer, the proceeds are payable directly to the lending institution as a credit against the loan balance. In this case, the provider is an indirect beneficiary.

B. Types of insurance which are considered an allowable cost area—

(I) Where credit life insurance is required as part of a mortgage loan agreement. An example would be insurance on loans granted under certain federal programs; and

(II) Where the relative(s) or estate of the employee, excluding stockholders, partners and proprietors, is the beneficiary. This type of insurance is considered to be a fringe benefit and is an allowable cost area to the extent that the amount of coverage is reasonable.

2. Retirement plans.

   A. Contributions to qualified retirement plans for the benefit of employees excluding stockholders, partners, and proprietors of the provider shall be allowable cost areas. Interest income from funded pensions or retirement plans shall be excluded from consideration in determining the allowable cost area.

   B. Amounts funded to pension and retirement plans, together with associated income, shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

3. Deferred compensation plans.

   A. Contributions for the benefit of employees, excluding stockholders, partners, and proprietors, under deferred compensation plans shall be all allowable cost areas when, and to the extent that, the costs are actually paid by the provider. Deferred compensation plans must be funded. Provider payments under unfunded deferred compensation plans will be considered as an allowable cost area only when paid to the participating employee and only to the extent considered reasonable.

   B. Amount paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

   C. Amounts funded to deferred compensation plans together with associated income shall be recaptured if not actually paid when due, as an offset to expenses on the cost report form.

(J) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance by the department.

2. Cost of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

(K) Organizational Cost Items.

1. Organizational cost items may be included as an allowable cost area on an amortized basis.

2. Organizational cost items include the following: legal fees incurred in establishing the corporation or other organizations, necessary accounting fees, expenses of temporary directors, and organizational meetings of directors and stockholders, and fees paid to states of incorporation.

3. Organizational costs shall be amortized ratably over a period of sixty (60) months beginning with the date of organization. When the provider enters the program more than sixty (60) months after the date of organization, no organizational costs shall be recognized.

4. Where a provider did not capitalize organizational costs and has written off those costs in the year they were incurred, the provider cannot retroactively capitalize any part of these costs under the program.

5. Where a provider is organized within a five- (5-) year period prior to entering the program and has properly capitalized organizational costs using a sixty- (60-) month amortization period, no change in the rate of amortization is required. In this instance the unamortized portion of organizational costs is an allowable cost area under the program and shall be amortized over the remaining part of the sixty- (60-) month period.

6. For change in ownership after July 18, 1984, allowable amortization will be limited to the prior owner's allowable unamortized portion of organizational cost.

(L) Advertising Costs. Advertising costs which are reasonable, appropriate, and helpful in developing, maintaining, and furnishing services shall be an allowable cost area. The costs must be common and accepted occurrence in the field of the activity of the provider.

(M) Cost of Suppliers Involving Related Parties. Costs applicable to facilities, goods, and services furnished to a provider by a supplier related to the provider shall not exceed the lower of the cost to the supplier or the prices of comparable facilities, goods, or services obtained elsewhere. A provider shall identify suppliers related to it in the uniform cost report and the type-quantity and costs of facilities, goods, and services obtained from each supplier.

(N) Utilization Review. Incurred cost for the performance of required utilization review for ICF/IID is an allowable cost area. The expenditures must be for the purpose of providing utilization review on behalf of a Title XIX participant. Utilization review costs incurred for Title XVIII and Title XIX must be apportioned on the basis of reimbursable participant days recorded for each program during the reporting period.

(O) Minimum Utilization. In the event the occupancy of a provider is below ninety percent (90%), the following cost centers will be calculated as if the provider experienced ninety percent (90%) occupancy: laundry, housekeeping, general, administrative, and plant operation costs. In no case may costs disallowed under this provision be carried forward to succeeding periods.

(P) Nonreimbursable Costs.

1. Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included as allowable costs.

2. Those services that are specifically provided by Medicare and MO HealthNet must be billed to those agencies.

3. Any costs incurred that are related to fund drives are not reimbursable.

4. Costs incurred for research purposes shall not be included as allowable costs.

5. The cost of services provided under the Title XX program, by contract or subcontract, is specifically excluded as an allowable item.

6. Attorney fees related to litigation involving state, local, or federal governmental entities and attorneys' fees which are not related to the provision of LTC services, such as litigation related to disputes between or among owners, operators, or administrators.

7. Costs, such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies, which are attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition of merger for which any payment has been previously made under the program.

(Q) Other Revenues. Other revenues, including those listed that follow and excluding amounts collected under paragraph (5)(A)8. will be deducted from the total allowable cost and must be shown separately in the cost report by use of a separate schedule if included in the gross revenue: income from telephone services; sale of employee and guest meals; sale of medical abstracts; sale of scrap and waste food or materials; rental income; cash, trade, quantity time, and other discounts; purchase rebates and refunds; recovery on insured loss; parking lot revenues; vending machine commissions or profit; sales from drugs to other than participants; income from investments of whatever type; and room reservation charges for temporary leave of absence days which are not covered services under section (5) of this plan. Failure to separately account for any of the revenues specifically set out previously in this plan in a readily ascertainable manner shall result in termination from the program.

1. Interest income received from a funded depreciation account will not be deducted from allowable operating costs provided that interest is applied to the replacement of the asset being depreciated.

2. Cost centers or operations specified by the provider in paragraph (6)(R) of this plan shall not have their associated cost or revenues included in the covered costs or revenues of the facility.

3. Restricted and unrestricted funds.

A. Restricted funds as used in this plan mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, which must be used only for a specific purpose designated by the donor. Those restricted funds which are not transferred funds and are designated by the donor for paying operating costs will be offset from the total allowable expenses. If an administrative body has the authority to re-restrict restricted funds designated by the donor for paying operating costs, the funds will not be offset from total allowable expenses.

B. Unrestricted funds as used in this plan mean those funds, cash or otherwise, including grants, gifts, taxes, and income from endowments, that are given to a provider without restriction by the donor as to their use. These funds can be used in any manner desired by the provider. However, those unrestricted funds which are not transferred funds and are used for paying operating costs will be offset from total allowable expenses.

C. Transferred funds as used in this plan are those funds appropriated through a legislative or governmental administrative body's action, state or local, to a state or local government provider. The transfer can be state-to-state, state-to-local, or local-to-local provider. These funds are not considered a grant or gift for reimbursement purposes, so have no effect on the provider's allowable cost under this plan.

(R) Apportionment of Costs to MO HealthNet Participant Residents.

1. Provider's allowable cost areas shall be apportioned between MO HealthNet program participant residents and other patients so that the share borne by the MO HealthNet program is based upon actual services received by program participants.

2. To accomplish this apportionment, apply the ratio of patient days for MO HealthNet participants to total patient days.

3. Average cost per diem for general routine services means the amount computed by dividing the total allowable patient costs for routine services by the total number of patient days of care rendered by the provider in the cost-reporting period.

4. A patient day of care is that period of service rendered a patient between the census-taking hours on two (2) consecutive days, including the twelve (12) temporary leave of absence days per any period of six (6) consecutive months as specifically covered under section (5) of this plan, the day of discharge being counted only when the patient was admitted the same day. A census log shall be maintained in the facility for documentation purposes. Census shall be taken daily at midnight. A day of care includes those overnight periods when a participant is away from the facility on a facility-sponsored group trip and remains under the supervision and care of facility personnel.

5. ICF/IID facilities that provide intermediate care services to MO HealthNet participants may establish distinct part cost centers in their facility provided that adequate accounting and statistical data required to separately determine the nursing care cost of each distinct part is maintained. Each distinct part may share the common services and facilities, such as management services, dietary, housekeeping, building maintenance, and laundry.

6. In no case may a provider's allowable costs allocated to the MO HealthNet program include the cost of furnishing services to persons not covered under the MO HealthNet program.

(S) Return on Equity.

1. A return on a provider's net equity shall be an allowable cost area.

2. The amount of return on a provider's net equity shall be calculated using the nursing home allowable percentage as defined in 13 CSR 70-10.015 Prospective Reimbursement Plan for Nursing Facility Services.

3. An owner's net equity is comprised of investment capital and working capital. Investment capital includes the investment in building, property, and equipment (cost of land, mortgage payments toward principle, and equipment purchase less the accumulative depreciation). Working capital represents the amount of capital which is required to ensure proper operation of the facility.

4. The return on owner's net equity shall be payable only to proprietary providers.

5. A provider's return on owner's net equity shall be apportioned to the MO HealthNet program on the basis of the provider's MO HealthNet program reimbursable participant resident days of care to total resident days of care during the cost-reporting period. For the purpose of this calculation, total resident days of care shall be the greater of ninety percent (90%) of the provider's certified bed capacity or actual occupancy during the cost year.

(T) Intermediate Care Facility for Individuals with Intellectual Disabilities Federal Reimbursement Allowance (ICF/IID FRA). The fee assessed to ICF/IIDs in the state of Missouri for the privilege of doing business in the state will be an allowable cost.

(7) Reporting Requirements.

(A) Annual Cost Report.

1. Each provider shall establish a twelve- (12-) month fiscal period which is to be designated as the provider's fiscal year. An annual cost report for the fiscal year shall be submitted by the provider to the department on forms to be furnished for that purpose. The completed cost report shall be submitted by each provider by the first day of the sixth month following the close of the fiscal period.

2. Unless adequate and current documentation in the following areas has been filed previously with the department, authenticated copies of the following documents must be submitted with the cost reports: authenticated copies of all leases related to the activities of the facility; all management contracts, all contracts with consultants; federal and state income tax returns for the fiscal year; and documentation of expenditures, by line item, made under all restricted and unrestricted grants. For restricted grants, a statement verifying the restriction as specified by the donor.

3. Adequate documentation for all line items on the uniform cost reports must be maintained by the facility and must be submitted to the department upon request.

4. If a cost report is more than ten (10) days past due, payment may be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with 13 CSR 70-10.030, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's MO HealthNet participation agreement and if terminated, retain all payments which have been withheld pursuant to this provision.

5. If a provider notifies, in writing, the director of the Institutional Reimbursement Unit of the division prior to the change of control, ownership, or termination of participation in the MO HealthNet program, the division may withhold all remaining payments from the selling provider until the cost report is filed. The fully completed cost report with all required attachments and documentation is due the first day of the sixth month after the date of change of control, ownership, or termination. Upon receipt of a cost report prepared in accordance with 13 CSR 70-10.030, any payment that was withheld will be released to the selling provider.

(B) Certification of Cost Reports.

1. The accuracy and validity of any cost report must be certified. Certification must be made by one (1) of the following persons (who must be authorized by the governing body of the facility to make the certification and will furnish proof of the authorization): an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner; or for a public facility, the chief administrative officer of the facility. The cost report must also be notarized by a licensed notary public.

2. Certification statement.

Form of Certification

Misrepresentation or falsifications of any information contained in this report may be punishable by fine, imprisonment, or both, under state or federal law.

Certification by officer or administrator of provider:

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by

_____

(Provider's name(s) and number(s))

for the cost report period beginning,_____, 20_____ and ending _____, 20____, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____ _____ _____

(Signature) *(Title)* *(Date)*

(C) Adequacy of Records.

1. The provider must make available to the department or its duly authorized agent, including federal agents from Health and Human Services (HHS), at all reasonable times, the records as are necessary to permit review and audit of provider's cost reports. Failure to do so may lead to sanctions available in section (8) of this rule.

2. All records associated with the preparation and documentation of the data associated with the cost report must be retained for seven (7) years from the cost report filing date.

(D) Accounting Basis.

1. The cost report submitted must be based on the accrual basis of accounting.

2. Governmental institutions that operate on a cash or modified cash basis of accounting may continue to use those methods, provided appropriate treatment of capital expenditures is made.

(E) Audits.

1. Cost reports shall be based upon the provider's financial and statistical records which must be capable of verification by audit.

2. If the provider has included the cost of a certified audit of the facility as an allowable cost item to the plan, a copy of that audit report and accompanying letter shall be submitted without deletions.

3. The annual cost report for the fiscal year of the provider may be subject to audit by the Department of Social Services or its contracted agents. Twelve- (12-) month cost reports for new construction facilities required to be submitted under section (4) of this plan may be audited by the department or its contracted agents prior to establishment of a permanent rate.

4. The department or authorized agent will conduct a desk review of all cost reports after submission by the provider and shall provide for on-site audits of facilities wherever cost variances or exceptions are noted by their personnel.

5. The department shall retain the annual cost report and any working papers relating to the audits of those cost reports for a period of not less than seven (7) full years from the date of submission of the report or completion of the audit.

6. Those providers having an annual Title XIX bed-day ratio on total bed days or certified beds of greater than sixty percent (60%) or an annual Title XIX payment of two hundred thousand dollars ($200,000) or more, or both, shall be required, for at least the first two (2) fiscal years of participation in the plan, to have an annual audit of their financial records by an independent certified public accountant. The auditor may issue a qualified audit report stating that confirmations of accounts receivable and accounts payable are not required by the plan. For the purposes of the paragraph, the Department of Social Services will only accept an unqualified opinion from a certified public accounting firm. A copy of the audit report must be submitted to the department to support the annual cost report of the facility.

(8) Sanctions and Overpayments.

(A) Sanctions may be imposed against a provider in accordance with 13 CSR 70-3.030 and other federal or state statutes and regulations.

(B) In the case of overpayments to providers based on, but not limited to, field or audit findings or determinations based on a comprehensive operational review of the facility, the provider shall repay the overpayment in accordance with the provisions as set forth in 13 CSR 70-3.030.

(9) Exceptions.

(A) For those MO HealthNet-eligible participant-patients who have concurrent Medicare Part A skilled nursing facilities benefits available, MO HealthNet reimbursement for covered days of stay in a qualified facility will be based on the coinsurance as may be imposed under the Medicare Program.

(B) The Title XIX reimbursement rate for out-of-state providers shall be set by one (1) of the following methods:

1. For providers which provided prior authorized services of fewer than one thousand (1,000) patient days for Missouri Title XIX participants, the reimbursement rate shall be the rate paid for comparable services and level-of-care by the state in which the provider is located; and

2. For providers which provide prior authorized services of one thousand (1,000) or more patient days for Missouri Title XIX participants, the reimbursement rate shall be the lower of—

A. The rate paid for comparable services and level-of-care by the state in which the provider is located; or

B. The rate calculated in section (4) of this plan.

(10) Payment Assurance.

(A) The state will pay each provider, which furnished the services in accordance with the requirements of the state plan, the amount determined for services furnished by the provider according to the standards and methods set forth in this plan.

(B) Where third-party payment is involved, MO HealthNet will be the payor of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Service. Procedures for remitting third-party payments are provided in the MO HealthNet program provider manuals.

(11) Provider Participation. Payments made in accordance with the standards and methods described in this plan are designed to enlist participation of a sufficient number of providers in the program so that eligible persons can receive medical care and services included in the state plan at least to the extent these services are available to the general public.

(12) Payment in Full. Participation in the program shall be limited to providers who accept as payment in full for covered services rendered to MO HealthNet participants, the amount paid in accordance with this plan and applicable copayments.

(13) Plan Evaluation. Documentation will be maintained to effectively monitor and evaluate experience during administration of this plan.

APPENDIX A
Routine Covered
Medical Supplies and Services

ABD Pads
A & D Ointment
Adhesive Tape
Aerosol Inhalators, Self-Contained
Aerosol, Other Types
Air Mattresses
Air P.R. Mattresses
Airway Oral
Alcohol
Alcohol Plasters
Alcohol Sponges
Antacids, Nonlegend
Applicators, Cotton-Tipped
Applicators, Swab-Eez
Aquamatic K Pads (water-heated pad)
Arm Slings
Asepto Syringes
Baby Powder
Bandages
Bandages (elastic or cohesive)
Bandaids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpan, Fracture
Bedpan, Regular
Bedside Tissues
Benzoin
Bibs
Bottle, Specimen
Canes
Cannula Nasal
Catheter Indwelling
Catheter Plug
Catheter Trays
Catheter (any size)

Colostomy Bags
Composite Pads
Cotton Balls
Crutches
Customized Crutches, Canes, and Wheelchairs
Decubitus Ulcer Pads
Deodorants
Disposable Underpads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressings (all)
Drugs, Stock (excluding Insulin)
Enema Can
Enema Soap
Enema Supplies
Enema Unit
Enemas
Equipment and Supplies for Diabetic Urine Testing
Eye Pads
Feeding Tubes
Female Urinal
Flotation Mattress or Biowave Mattress
Flotation Pads, Turning Frames, or both
Folding Foot Cradle
Gastric Feeding Unit
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hand-Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Ice Bags

Incontinency Care
Incontinency Pads and Pants
Infusion Arm Boards
Inhalation Therapy Supplies
Intermittent Positive Pressure Breathing Machine (IPPB)
Invalid Ring
Irrigation Bulbs
Irrigation Trays
I.V. Trays
Jelly, Lubricating
Laxatives, Nonlegend
Lines, Extra
Lotion, Soap, and Oil
Male Urinal
Massages (by nurses)
Medical Social Services
Medicine Cups
Medicine Dropper
Merthiolate Aerosol
Mouthwashes
Nasal Cannula
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding
Nebulizer and Replacement Kit
Needles (hypodermic, scalp, vein)
Needles (various sizes)
Nonallergic Tape
Nursing Services (all) regardless of level including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing (other than items of personal comfort or cosmetic)
Overhead Trapeze Equipment
Oxygen Equipment (such as IPPB machines and oxygen tents)
Oxygen Mask
Pads
Peroxide
Pitcher
Plastic Bib
Pump (aspiration and suction)
Restraints
Room and Board (semiprivate or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Sheepskin

Special Diets
Specimen Cups
Sponges
Steam Vaporizer
Sterile Pads
Stomach Tubes
Stool Softeners, Nonlegend
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tape
Suture Removal Kit
Suture Trays
Syringes (all sizes)
Syringes, Disposable
Tape (for laboratory test)
Tape (nonallergic or butterfly)
Testing Sets and Refills (S & A)
Tongue Depressors
Tracheostomy Sponges
Tray Service
Tubing I.V. Trays, Blood Infusion
Set, I.V. Tubing
Underpads
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Vitamins, Nonlegend
Walkers
Water Pitchers
Wheelchairs

This is the last page of the Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/IID Services. Pages 205-223 were deleted as a result of SPA 19-0006.