12-011 Rates for Nursing Facility Services

12-011.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447.250 through 42 CFR 447.272;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective for services provided beginning July 1, 2009.

12-011.02 Definitions: The following definitions apply to the nursing facility rate determination system.

Allowable Cost means those facility costs which are included in the computation of the facility's per diem. The facility's reported costs may be reduced because they are not allowable under Medicaid or Medicare regulation, or because they are limited under 471 NAC 12-011.06.

Assisted Living Rates means standard rates, single occupancy, rural or urban, per day equivalent, paid under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Department means the Nebraska Department of Health and Human Services.

Division means the Division of Medicaid and Long-Term Care.

Level of Care means the classification (see 471 NAC 12-013.01) of each resident based on his/her acuity level.

Median means a value or an average of two values in an ordered set of values, below and above which there is an equal number of values.

Nursing Facility means an institution (or a distinct part of an institution) which meets the definition and requirements of Title XIX of the Social Security Act, Section 1919.

Rate Determination means per diem rates calculated under provisions of 471 NAC 12-011.08. These rates may differ from rates actually paid for nursing facility services for Levels of Care 35 and 36.

Rate Payment means per diem rates paid under provisions of 471 NAC 12-011.08. The payment rate for Levels of Care 35 and 36 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

Revisit Fees means fees charged to health care facilities by the Secretary of Health and Human Services to cover the costs incurred under 'Department of Health and Human Services, Centers for Medicare and Medicaid Services, Program Management' for conducting revisit surveys on health care facilities cited for deficiencies during initial certification, recertification or substantiated complaint surveys.

Urban means Douglas, Lancaster, Sarpy, and Washington Counties.

Waivered Facility means facilities for which the State Certification Agency has waived professional nurse staffing requirements of OBRA 87 are classified as "waivered" if the total number of waivered days exceeds 90 calendar days at any time during the reporting period.

Weighted Resident Days means a facility's inpatient days, as adjusted for the acuity level of the residents in that facility (see 471 NAC 12-013.03 and 12-013.04).

Other definitions which apply in this section are included in Nebraska Department of Health and Human Services Division of Public Health's regulations in Title 175, Chapter 12, Skilled Nursing Facilities, Nursing Facilities, and Intermediate Care Facilities and appropriate federal regulations governing Title XIX and Title XVIII.

12-011.03 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as of July 1, 2007 are used in determining the cost for Nebraska nursing facilities with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

A provider with 1,000 or fewer Medicaid inpatient days during a complete fiscal year Report Period (see 471 NAC 12-011.08B) will not file a cost report. The rate paid will be the average base rate components, effective July 1, 2009, of all other providers in the same care classification, computed using audited data as of March 15, 2009.

12-011.04 Allowable Costs: The following items are allowable costs under NMAP.

12-011.04A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition and requirements for a Nursing Facility of Title XIX of the Social Security Act, Section 1919;

12-011.06K Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). Administrator compensation maximums for the cost report period ending June 30, 2008 are:

Bed Size	Maximum
1-74	$78,062
75-99	$79,464
100-149	$94,422
150-200	$95,357
201 +	$140,231

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

12-011.06L Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise allowable Direct Nursing and Support Services Components for the facility.

This computation is made by dividing the total allowable Direct Nursing and Support Services Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Direct Nursing and Support Services components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

12-011.06P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

12-011.07 (Reserved)

12-011.08 Rate Determination: The rate determination provisions of 471 NAC 12-011.08 are in effect beginning July 1, 2009. The Department determines rates for facilities under the following cost-based prospective methodology.

12-011.08A Rate Period: The Rate Period is defined as July 1, 2009 through June 30, 2010. Rates paid during this Rate Period are determined (see 471 NAC 12-011.08D) from cost reports submitted for the June 30, 2008 Report Period (see 471 NAC 12-011.08B).

12-011.08B Report Period: Each facility must file a cost report each year for the twelve-month reporting period of July 1 through June 30.

12-011.08C Care Classifications: A portion of each individual facility's rate may be based on the urban or non-urban location of the facility.

12-011.08D Prospective Rates: Subject to the allowable, unallowable, and limitation provisions of 471 NAC 12-011.04, 12-011.05, and 12-011.06, the Department determines facility-specific prospective per diem rates (one rate corresponding to each level of care) based on the facility's allowable costs incurred and documented during the July 1, 2007 through June 30, 2008 Report Period. The rates are based on financial, acuity, and statistical data submitted by facilities, and are subject to the Component maximums.

Component maximums are computed using audited data as of the March 15th following the end of the Cost Report Period, and are not revised based on subsequent desk audits or field audits. Only cost reports with a full year's data are used in the computation. Cost reports from providers entering or leaving the NMAP during the immediately preceding Report Period are not used in the computation.

Each facility's prospective rates consist of three components:

1. The Direct Nursing Component increased by the inflation factor;
2. The Support Services Component increased by the inflation factor; and
3. The Fixed Cost Component.

The Direct Nursing Component and the Support Services Component are subject to maximum per diem payments based on Median/Maximum computations.

Median: For each Care Classification, the median for the Direct Nursing Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding waivered, and/or facilities with partial or initial/final full year cost reports. For each Care Classification, the median for the Support Services Component is computed using nursing facilities within that Care Classification with an average occupancy of 40 or more residents, excluding hospital based, waivered, and/or facilities with partial or initial/final full year cost reports.

The Department will reduce the Direct Nursing Component median by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

Maximum: The maximum per diem is computed as 125% of the median Direct Nursing Component, and 115% of the median Support Services Component. The Department will reduce the Direct Nursing Component maximum by 2% for facilities that are waivered from the 24-hour nursing requirement to take into account those facilities' lowered nursing care costs.

The Fixed Cost Component is subject to a maximum per diem of $27.00, excluding personal property and real estate taxes.

Each facility's base prospective rate is computed as the sum of the facility-specific Direct Nursing and Support Services components adjusted by the inflation factor and the Fixed Cost Component, subject to the rate limitations and component maximums of this system. The Direct Nursing, Support Services, and Fixed Cost components are expressed in per diem amounts.

12-011.08D1 Direct Nursing Component: This component of the prospective rate is computed by dividing the allowable direct nursing costs (lines 94 through 103 of Form FA-66, "Long Term Care Cost Report") by the weighted resident days for each facility (see 471 NAC 12-013.03). The resulting quotient is the facility's "base" per diem. Rate determination for the Direct Nursing Component for an individual facility is computed using the lower of its own base per diem, weighted for levels of care, or the maximum base per diem, weighted for levels of care.

12-011.08D2 Support Services Component: This component of the prospective rate is computed by dividing the allowable costs for support services (lines 34, 63, 78, 93, 104 through 127, 163, 184, and 185 from the FA-66); Resident Transportation - Medical from the Ancillary Cost Center (lines 211 through 218 from the FA-66); and respiratory therapy from the Ancillary Cost Center (lines 203 through 210 from the FA-66), by the total inpatient days (see 471 NAC 12-011.06B) for each facility. Rate determination for the Support Services Component for an individual facility is computed using the lower of its own per diem or the maximum per diem.

12-011.08D3 Fixed Cost Component: This component of the prospective rate is computed by dividing the facility's allowable interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs by the facility's total inpatient days (see 471 NAC 12-011.06B). Rate determination for the Fixed Cost Component for an individual facility is computed using the lower of its own per diem as computed above, or a maximum per diem of $27.00 excluding personal property and real estate taxes.

12-011.08D4 Inflation Factor: For the Rate Period of July 1, 2009 through June 30, 2010, the inflation factor is 0.78%.

12-011.08E Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increase(s).

12-011.08F Rate Payment for Levels of Care 35 and 36: Rates as determined for Levels of Care 35 and 36 under the cost-based prospective methodology of 471 NAC 12-011.08A through 12-011.08E may be adjusted for actual payment. The payment rate for Levels of Care 35 and 36 is the applicable rate in effect for assisted living services under the Home and Community-Based Waiver Services for Aged Persons or Adults or Children with Disabilities (see 480 NAC 5).

12-011.08G Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreements. The payment is not subject to any type of adjustment.

12-011.08H Rates for New Providers Entering NMAP after July 1, 2007:

Definition: A provider is any individual or entity which furnishes Medicaid goods or services under an approved provider agreement with the Department. A new provider is an individual or entity which obtains their initial, facility-specific provider agreement to operate an existing nursing facility due to a change in ownership, or to operate a nursing facility not previously enrolled in NMAP. For purposes of this definition, "nursing facility" means the business operation, not the physical property.

For the July 1, 2009 through June 30, 2010 Rate Period, the Department will pay new providers interim rates determined as follows:

1. For new providers entering NMAP from July 2, 2007 through June 30, 2008, the interim rates for the rate period July 1, 2009 through June 30, 2010 are the rates computed from the provider's initial, part-year cost report for the period ending June 30, 2008, subject to the rate period's maximums and limitations. Interim rates for the July 1, 2009 through June 30, 2010 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2010, subject to maximums and limitations applicable to the 2009-2010 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period.

2. For new providers entering NMAP as a result of a change of ownership from July 1, 2008 through June 30, 2009, the interim rates for the rate period July 1, 2009 through June 30, 2010 are the rates computed from the seller's cost report for the period ending June 30, 2008, subject to maximums and limitations applicable to the 2009-2010 rate period.

   For other new providers entering NMAP from July 1, 2008 through June 30, 2009, the initial interim rates for the rate period July 1, 2009 through June 30, 2010 are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data. The initial interim rates will be revised based on the provider's audited June 30, 2009 cost report, subject to maximums and limitations applicable to the 2009-2010 rate period. The revised interim rates will be issued within ten days of the completion of the initial desk audit of the facility's cost report.

   Interim rates and revised interim rates for the July 1, 2009 through June 30, 2010 rate period will be retroactively settled based on the provider's audited cost report for the period ending June 30, 2010, subject to maximums and limitations applicable to the 2009-2010 rate period. Providers with 1,000 or fewer annualized Medicaid days during a report period will not file a cost report and will not be subject to a retro-settlement of their rates for that period.

3. For new providers entering NMAP as a result of a change of ownership from July 1, 2009 through June 30, 2010, the interim rates for the rate period beginning with the sale date through June 30, 2010 are the rates of the seller in effect on the sale date.

   For other new providers entering NMAP from July 1, 2009 through June 30, 2010, the interim rates for the rate period beginning with the sale date through June 30, 2010, are the average base rate components effective at the beginning of the rate period, of all other providers in the same Care Classification, computed using the applicable March 15th audited data.

12-011.08J Providers Leaving the NMAP: Providers leaving the NMAP as a result of change of ownership or exit from the program shall comply with provisions of 471 NAC 12-011.10, Reporting Requirement and Record Retention.

12-011.08K Special Funding Provisions for Governmental Facilities: City or county-owned facilities are eligible to participate in the following transactions to increase reimbursement. Both transactions are subject to the payment limits of 42 CFR 447.272 (payments may not exceed the amount that can reasonable be estimated to be paid under Medicare payment principles). City or county owned refers to the common meaning of ownership of the physical structure(s); the governmental entity may or may not be directly involved in the daily operation of the facility.

1. City or county-owned facilities with a 40% or more Medicaid mix of inpatient days are eligible to receive the Federal Financial Participation share of allowable costs exceeding the applicable maximums for the Direct Nursing and the Support Services Components. This amount is computed after desk audit and determination of final rates for a Report Period by multiplying the current NMAP Federal Financial Participation percentage by the facility's allowable costs above the respective maximum for the Direct Nursing and the Support Services Components. Verification of the eligibility of the expenditures for FFP is accomplished during the audit process.
2. City or county-owned facilities may also participate in the proportionate share pool. The proportionate share pool is calculated by comparison of the Nebraska Medicaid care classification of residents (see 471 NAC 12-013 Classification of Residents and Corresponding weights) to Medicare's RUG III care classifications. Each facility's Medicare rates, adjusted by the wage index published in the Federal Register are compared to equivalent Medicaid rates by resident. When more than one Medicare classification could be applicable to a Medicaid classification, an arithmetic average of the Medicare rates is computed.

The methodology adjusts for pharmacy, laboratory, radiology, retroactive payment adjustments (including adjustments made under 471 NAC 12-011.08K, item 1), and any other factors necessary to equate Medicaid to Medicare payment methodologies.

31-008 Payment for ICF/MR Services

31-008.01 Purpose: This section:

1. Satisfies the requirements of the State Plan for Medical Assistance and 42 CFR 447, Subpart C, which provide for payment of ICF/MR services;
2. Adopts rate setting procedures which recognize the required level and quality of care as prescribed by all governmental entities (including, but not limited to, federal, state, and local entities);
3. Establishes effective accountability for the disbursement of Medical Assistance appropriations; and
4. Provides for public notice of changes in the statewide method or level of payment pursuant to the requirements of Section 1902(a)(13) of the Social Security Act.

The rate determination described herein is effective beginning July 1, 2009.

31-008.02 General Information: Wherever applicable, the principles of reimbursement for provider's cost and the related policies under which the Medicare extended care facility program functions (Medicare's Provider Reimbursement Manual (HIM-15) updated by "Provider Reimbursement Manual Revisions" in effect as July 1, 2007) are used in determining the cost for Nebraska ICF/MRs with exceptions noted in this section. Chapter 15, Change of Ownership, of HIM-15 is excluded in its entirety.

That portion of a provider's allowable cost for the treatment of Medicaid patients is payable under the Nebraska Medical Assistance Program (NMAP) except as limited in this section. The aggregate payments by the Department do not exceed amounts which would be paid under Title XVIII principles of reimbursement for extended care facilities.

31-008.03 Allowable Costs: The following items are allowable costs under NMAP.

31-008.03A Cost of Meeting Licensure and Certification Standards: Allowable costs for meeting licensure and certification standards are those costs incurred in order to:

1. Meet the definition in 42 CFR 440.150;
2. Comply with the standards prescribed by the Secretary of Health and Human Services (HHS) in 42 CFR 442;
3. Comply with requirements established by the Nebraska Department of Health and Human Services, Division of Public Health, the agency responsible for establishing and maintaining health standards, under 42 CFR 431.610; and
4. Comply with any other state law licensing requirements necessary for providing skilled nursing or intermediate care facility, as applicable.

31-008.03B Items Included in Per Diem Rates: The following items are included in the per diem rate:

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11. Services provided by the clients' physicians or dentists, drugs, laboratory services, radiology services, or services provided by similar independent licensed providers, except services provided by state-operated facilities. These exclusions are paid separately;
12. Return on equity;
13. Carry-over of costs "lost" due to any limitation in this system; and
14. Expenses for equipment, facilities, and programs (e.g., recreation, trips) provided to clients that are determined by the Department not to be reasonably related to the efficient production of service because of either the nature or amount of the particular service. Examples include, but are not limited to, swimming pools, tennis courts, handball courts. Recreational and therapeutic facilities necessary for the needs of persons with mental retardation in ICF/MR's will be allowed.

31-008.05 Limitations for Rate Determination: The Department applies the following limitations for rate determination to ICF/MRs that are not State-operated.

31-008.05A Expiration or Termination of License or Certification: The Department does not make payment for care provided 30 days after the date of expiration or termination of the provider's license or certificate to operate under NMAP. The Department does not make payment for care provided to individuals who were admitted after the date of expiration or termination of the provider's license or certificate to operate under NMAP.

31-008.05B Total Inpatient Days: Total inpatient days are days on which the patient occupies the bed at midnight or the bed is held for hospital leave or therapeutic home visits. Payment for holding beds for patients in acute hospitals or on therapeutic home visits is permitted if the policy of the facility is to hold beds for private patients and if the patient's bed is actually held. Bedholding is allowed for 15 days per hospitalization and up to 36 days of therapeutic home visits per calendar year for an ICF/MR client.

Medicaid inpatient days are days for which claims (Printout MC-4, "Long Term Care Facility Turnaround Billing Document") or the standard electronic Health Care Claim: Institutional transaction (ASC X12N 837") from the provider have been processed by the Department. The Department will not consider days for which a claim has not been processed unless the provider can show justification to the Department's satisfaction. Days for which the client's Medicaid eligibility is in a "spenddown" category are not considered Medicaid inpatient days.

Exception: When a client is admitted to an ICF/MR and dies before midnight on the same day, the Department allows payment for one day of care. The day is counted as one Medicaid inpatient day.

31-008.05B1 For ICF/MRs with 16 beds or more: In computing the provider's allowable cost per day for determination of the rate, total inpatient days are the greater of the actual occupancy or 85 percent of total licensed bed days.

31-008.05B2 For ICF/MRs with 4-15 beds: In computing the provider's allowable cost per day for determination of the rate, total inpatient days for fixed costs are the greater of actual inpatient days or 85% of licensed beds. For computing the non-fixed costs per day the actual patient days are utilized.

31-008.05C New Construction, Reopening, and Certification Changes: For new construction (entire facility or bed additions), facility reopening, or a certification change from Nursing Facility to ICF/MR total inpatient bed days available are the greater of actual occupancy or 50 percent of total licensed bed days available during the first year of operation, beginning with the first day patients are admitted for care.

31-008.05D Start-Up Costs: All new providers entering NMAP after July 31, 1982, must capitalize and amortize their allowable start-up costs. Only those costs incurred three months before the admission of the first resident (private or Medicaid) may be capitalized and amortized. These costs must be documented and submitted with the provider's initial cost report. Amortization of these costs begins on the date of the first admission and must extend over at least 36 months, but must not exceed 60 months. Start-up costs include, for example, administrative and nursing salaries, heat, gas, electricity, taxes, insurance, interest, employee training costs, repairs and maintenance, housekeeping, and any other allowable costs incidental to the start-up period.

31-008.05E Customary Charge: The Department does not use HIM-15, Chapter 26 policies and procedures. Average customary charge is defined as net revenue (total charges for covered services reduced by charity and courtesy allowances, bad debts, and other uncollected charges) derived from "private" residents divided by the "private" inpatient days (including applicable bedholding).

Facilities in which private resident days are less than 5 percent of the total inpatient days, as defined in 471 NAC 31-008.05B, will not be subject to the customary charge limitation.

31-008.05E1 ICF/MRs with 16 beds or more:
An ICF/MR's payment for ICF/MR services must not exceed the ICF/MR's projected average customary charge to the general public for the same level of care services, except for public facilities providing services at a nominal charge.

The projected average customary charge is computed by adjusting the average customary charge by an amount equal to the lesser of the average customary charge or the allowable operating cost, as computed for the most recent report period, increased by the Inflation Factor (see 471 NAC 31-008.06C7) for the most recent report period.

31-008.05E2 ICF/MRs with 4-15 beds:
An ICF/MR's final rate for ICF/MR services must not exceed the ICF/MR's average customary charge to the general public for the same retroactively settled payment period, for the same level of care services, except for public facilities providing services at a nominal charge.

31-008.05F Common Ownership or Control: Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control must not exceed the lower of the cost to the related organization or the price of comparable services, facilities, or supplies purchased elsewhere. An exception to the general rule applies if the provider demonstrates by convincing evidence to the Department's satisfaction that:

1. The supplying organization is a bona fide separate organization;
2. A substantial part of the supplying organization's business activity is transacted with others than the provider and organizations related to the supplier by common ownership or control, and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization;
3. The services, facilities, or supplies are those which commonly are obtained by institutions like the provider from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by similar institutions; (Costs of contracted labor obtained from a related party are limited to the salaries paid to the individual workers for their time working at the facility, plus applicable payroll taxes and employee benefits. The exception to the related party rule does not apply.); and
4. The charge to the provider is in line with the charge for those services, facilities, or supplies in the open market, and is no more than the charges made under comparable circumstances to others by the organization for those services, facilities, or supplies.

When all conditions of this exception are met, the charges by the supplier to the provider for services, facilities, or supplies are allowable as costs.

31-008.05G Leased Facilities: Allowable costs for leased facilities (including, but not limited to, leases, subleases, and other similar types of contractual arrangements), including all personal property covered in the lease, entered into after July 31, 1982, must not exceed the actual cost of the lessor for depreciation, interest on lessor's mortgage, and other costs of ownership incurred as a condition of the lease. If the lessor sells the facility, all provisions of 471 NAC 31-008.05J will apply, except that the Department does not recapture depreciation on leases between unrelated parties. All interest must be specifically identified or reasonably allocated to the asset. All actual costs to the lessor are computed according to the rate setting principles of this section. If costs are claimed for leases, the lease agreement must provide that the lessor will:

1. Provide an itemized statement at the end of each provider's report period which includes depreciation, interest, and other costs incurred as a condition to the lease; and
2. Make records available for audit upon request of the Department, the federal Department of Health and Human Services (HHS), or their designated representatives.

31-008.05H Interest Expense: For rate periods beginning January 1, 1985, interest cost will not be allowed on loan principal balances which are in excess of 80 percent of the fixed asset cost recognized by the Department for ICF/MR care. This limitation does not apply to government owned facilities.

31-008.05J Recognition of Fixed Cost Basis: The fixed cost basis for facilities purchased as an ongoing operation or for newly constructed facilities or facility additions is the lesser of:

1. The acquisition cost of the asset to the new owner;
2. The acquisition cost which is approved by the Nebraska Department of Health and Human Services, Division of Public Health Certificate of Need process; or
3. For facilities purchased as an ongoing operation on or after December 1, 1984, the allowable cost of the asset to the owner of record as of December 1, 1984, or for assets not in existence as of December 1, 1984, the first owner of record thereafter.

471 NAC 31-008.07E, Recapture of Depreciation, will apply to this part.

Costs (including legal fees, accounting and administrative costs, travel costs, and the costs of feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) for which any payment has previously been made are not allowable.

This part will not apply to changes of ownership of assets pursuant to an enforceable agreement entered into before December 1, 1984.

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department, for the purposes of rate setting, is the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

31-008.05K Certificate of Need Approved Projects: Notwithstanding any other provision of 471 NAC 31-008, the fixed costs reported to the Department for a Division of Public Health Certificate of Need reviewed project must not exceed the amount that would result from the application of the approved project provisions including the estimated interest rates and asset lives.

Certificate of Need provisions recognized by the Department, for the purposes of rate setting, is the original project as approved, the approved project amendments submitted within 90 days of the transfer of ownership or opening of newly constructed areas, and the allowable cost overruns disclosed in a final project report submitted to the Division of Public Health within 180 days of the opening of newly constructed areas. Project amendments and project reports submitted to the Division of Public Health Certificate of Need after the periods defined above will be recognized upon approval beginning on the date that the amendment or report is received by the Division of Public Health. The added costs incurred before the date the late amendment or report is filed will not be recognized retroactively for rate setting.

ICF/MRs with 4-15 beds are excluded from Certificate of Need requirements.

31-008.05L Salaries of Administrators, Owners, and Directly Related Parties: Compensation received by an administrator, owner, or directly related party is limited to a reasonable amount for the documented services provided in a necessary function. Reasonable value of the documented services rendered by an administrator is determined from Medicare regulations and administrator salary surveys for the Kansas City Region, adjusted for inflation by the federal Department of Health and Human Services (see HIM-15, Section 905.6). Administrator compensation maximums for the cost report period ending June 30, 2008 are:

Bed size	Maximum
1 - 74	$78,062
75 - 99	$79,464
100 - 149	$94,422
150 - 200	$95,357
201 +	$140,231

All compensation received by an administrator is included in the Administration Cost Category, unless an allocation has prior approval from the Department. Reasonable value of the documented services rendered by an owner or directly related party who hold positions other than administrator is determined by: (1) comparison to salaries paid for comparable position(s) within the specific facility, if applicable, or, if not applicable, then (2) comparison to salaries for comparable position(s) as published by the Department of Administrative Services, Division of State Personnel in the "State of Nebraska Salary Survey".

31-008.05M Administration Expense: In computing the provider's allowable cost for determination of the rate, administration expense is limited to no more than 14 percent of the total otherwise Personnel Operating and Non-Personnel Operating Cost Components for the facility.

This computation is made by dividing the total allowable Personnel Operating and Non-Personnel Operating Cost Components, less the administration cost category, by 0.86. The resulting quotient is the maximum allowable amount for the Personnel Operating and Non-Personnel Operating Cost components, including the administration cost category. If a facility's actual allowable cost for the two components exceeds this quotient, the excess amount is used to adjust the administration cost category.

31-008.05N Facility Bed Size Exception: For the rate period July 1, 2009 through June 30, 2010, rates for any privately-owned ICF/MR with less than 16 beds that was receiving Medicaid reimbursement prior to July 1, 2009 will be determined based on the methodology described in 471 NAC 31-008.06C for ICF/MRs with 16 or more beds.

31-008.05P Other Limitations: Other limitations to specific cost components of the rate are included in the rate determination provision of this system.

31-008.06 Rate Determination: The Department determines rates under the following guidelines:

31-008.06A Rate Period: The Rate Period is defined for non-State- operated ICF/MR providers for services provided from July 1, 2009 through June 30, 2010. The Rate Period for State-Operated ICF/MR providers is defined as a calendar year.

31-008.06B Reporting Period: Each facility must file a cost report each year for the reporting period ending June 30.

31-008.06C Rates for Intermediate Care Facility for the Mentally Retarded (ICF/MR) Excluding State-Operated ICF/MR Providers:

31-008.06C1 ICF/MRs with 16 beds or more:
Effective July 1, 2009, subject to the allowable, unallowable, and limitation provisions of this system, the Department pays each facility a prospectively determined amount based on the facility's allowable, reasonable and adequate costs incurred and documented during the July 1, 2007 through June 30, 2008 Report Period. The per diem rates are based on financial and statistical data submitted by the facilities. Individual facility prospective rates have five components:

1. The ICF/MR Personnel Operating Cost Component increased by the inflation factor;
2. The ICF/MR Non-Personnel Operating Cost Component increased by the inflation factor;
3. The ICF/MR Fixed Cost Component;
4. The ICF/MR Ancillary Cost Component increased by the inflation factor; and
5. The ICF/MR Revenue Tax Cost Component.

An ICF/MR facility's prospective rate is the sum of the five components.

31-008.06C2 ICF/MRs with 4-15 beds:

31-008.06C2a Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a fiscal year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06C2b Final Rate: The Department pays each ICF/MR with 4-15 beds a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and
5. The ICF/MR Revenue Tax Cost Component. This component is not retroactively settled (see 31-008.06C8b).

The final rate is the sum of the above five components.

31-008.06C3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry and housekeeping, property and plant, and administrative services.

31-008.06C3a ICF/MRs with 16 or more beds:
Both the resident care services and the support services portions of the personnel operating cost component of the prospective rate are the lower of:

1. The allowable personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7, or
2. The facility's Personnel Operating Cost Model, adjusted by the Inflation Factor computed under provisions of 471 NAC 31-008.06C7.

31-008.06C3b Personnel Operating Cost Model: The personnel operating cost model cost per day for each facility is determined based on each facility's average actual occupancy per day limited to an average occupancy of not less than 15 residents per day, level of care resident mix, staffing standards, and reasonable wage rates as adjusted for reasonable fringe benefits.

31-008.06C3b(1) Staffing Standards: The following staffing standards, in combination with the standard wage rates as described in 471 NAC 31-008.06C3b(2), are used to determine each facility's efficient and adequate personnel cost. The 19 staff categories and respective standards are used to determine total efficient and adequate personnel cost and are not intended to be required staffing levels for each staff category. All standard hours per resident day are paid hours and, therefore, include vacation, sick leave, and holiday time.

The staff categories and standards are as follows:

Hours per Resident Day	
Staff Categories	All
Direct Care Staff -Aides, attendants, houseparents, counselors, house managers	6.5160
Direct Care Admin. -QMRPs, residential service/ program coordinators, direct care supervisors	0.9105

Hours per Resident Day	
Active Treatment Services	All
-Physical therapists & assistants	0.0620
-Occupational therapists & assistants	0.0830
-Psychologists	0.0940
-Speech therapists & audiologists	0.0700
-Social workers	0.1390
-Recreation therapists	0.1460
-Other professional & technical staff	0.4330
Medical Services	
-Health services supervisor	see description following
-Registered nurses	see description following
-LPN or vocational nurses	0.1975
Dietary	
-Dietitian, nutritionists	0.0230
-Food service staff	0.5540
Laundry & Housekeeping	
-Laundry & housekeeping personnel	0.3940
Property & Plant	
-Maintenance personnel	0.3000
Administration	
-Administrator	see description following
-Assistant administrators	see description following
-Other support personnel	see description following

The standard for the Health Services Supervisor position is one full-time equivalent employee, which will result in a varying number of standard hours per resident day depending upon the number of resident days. The standard hours per resident day for registered nurses are 0.1885 reduced by the Health Services Supervisor hours per resident day. However, these standard hours may not reduce the facility below one full-time equivalent for the combined Health Services Supervisor and R.N. positions.

The standard for the Administrator position is one full-time equivalent employee. The standard for assistant administrators is based on facility size and is as follows:

Number of Residents	Number of Assistant Administrators
1 to 100	None
101 to 200	1
201 to 300	2
301 to 400	3
401 to 500	4
501 and over	5

For other support personnel, the standard hours per resident day are 0.608, reduced by the assistant administrators' hours per resident day.

31-008.06C3b(2) Standard Wage Rates: Wage rates for each personnel category will be determined annually based on the actual average wage rates of the Beatrice State Developmental Center for the current cost report period.

31-008.06C3c ICF/MRs with 4-15 beds:
Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C4 ICF/MR Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers.

31-008.06C4a ICF/MRs with 16 beds or more:
The nonpersonnel operating cost component of the prospective rate is the lower of:

1. The allowable non-personnel operating cost per day as computed for the facility's most recent cost report period, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC31-008.06C7;
2. 110 percent of the mean allowable non-personnel operating cost per day for all ICF/MR facilities, adjusted by a percentage equal to the Inflation Factor computed under 471 NAC31-008.06C7; or
3. 30 percent of the weighted mean for all ICF/MR facilities Personnel Operating Cost Model adjusted by the Inflation Factor computed under 471 NAC31-008.06C7. The mean will be weighted by the Nebraska Medicaid ICF/MR days.

31-008.06C4b ICF/MRs with 4-15 beds:
The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06C5 ICF/MR Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, gross revenue tax, and other fixed costs. The fixed cost component is the allowable fixed cost per day as computed for the facility's most recent cost report period.

31-008.06C6 ICF/MR Ancillary Cost Component: The ancillary cost component of the rate is the allowable ancillary cost per day as computed for the facility's most recent report period.

31-008.06C7 ICF/MR Inflation Factor: For the Rate Period of July 1, 2009 through June 30, 2010, the inflation factor is 5.0%.

31-008.06C8 ICF/MR Revenue Tax Cost Component:

31-008.06C8a ICF/MRs with 16 or more beds:
Under the ICF/MR Reimbursement Protection Act, for the Rate Period July 1, 2009 through June 30, 2010, the ICF/MR revenue tax per diem is computed as the ICF/MR revenue tax based on State Fiscal Year 2008-09 net revenue divided by State Fiscal Year 2008-09 facility resident days. (See 405 NAC 1-003.)

31-008.06C8b ICF/MRs with 4-15 beds:
Under the ICF/MR Reimbursement Protection Act, the ICF/MR revenue tax per diem is computed as the prior report period net revenue times the applicable tax percentage(s) divided by the prior report period facility resident days. (See 405 NAC 1-003.)

31-008.06C9 ICF/MR Exception Process: An individual facility may request, on an exception basis, the Director of the Division of Medicaid and Long-Term Care to consider specific facility circumstance(s), which warrant an exception to the facility's rate computed for its Fixed Cost Component. An exception may only be requested if the facility's total fixed costs (total costs, not per diem rate), as compared to the immediately prior report period, have increased by ten percent or more. In addition, the facility's request must include:

1. Specific identification of the increased cost(s) that have caused the facility's total fixed costs to increase by 10 percent or more, with justification for the reasonableness and necessity of the increase;
2. Whether the cost increase(s) are an ongoing or a one-time occurrence in the cost of operating the facility; and
3. If applicable, preventive management action that was implemented to control past and future cause(s) of identified cost increases(s).

31-008.06D Rates for State-Operated Intermediate Care Facilities for the Mentally Retarded (ICF/MR): The Department pays State-operated ICF/MR providers an amount equivalent to the reasonable and adequate costs incurred during each Reporting Period. An interim per diem rate is paid during the calendar year Rate Period, based on financial and statistical data as submitted by the ICF/MR for the most recent Reporting Period. The interim rate is settled retroactively to the facility's actual costs, which determine the Final Rate. The rate has five components:

1. The Personnel Operating Cost Component;
2. The Non-Personnel Operating Cost Component;
3. The Fixed Cost Component;
4. The Ancillary Cost Component; and

The ICF/MR Revenue Tax Cost Component.

The rate is the sum of the above five components. Rates cannot exceed the amount that can reasonably be estimated to have been paid under Medicare payment principles.

31-008.06D1 Interim Rate: The interim rate is a per diem paid for each inpatient day. An interim rate is paid during a calendar year rate period and then retroactively adjusted when final cost and census data is available. The Interim Rate is a projection and is intended to approximate the Final Rate as closely as is possible. Projections are made from known current data and reasonable assumptions.

31-008.06D2 Final Rate: The Department pays each ICF/MR a retroactively determined per diem rate for the reasonable and adequate costs incurred and documented for the most recent reporting period.

31-008.06D3 Personnel Operating Cost Component: This component includes salaries, wages, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expense for resident care services and support services. The resident care services portion consists of direct care staff, direct care administration, active treatment, and medical services. The support services portion consists of dietary, laundry, and housekeeping, property and plant, and administrative services. Both the resident care services and the support services portions of the personnel operating cost component of the Final Rate are the allowable personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D4 Non-Personnel Operating Cost Component: This component includes all costs other than salaries, fringe benefits, the personnel cost portion of purchased services, and the personnel cost portion of management fees or allocated expenses for the administrative, dietary, housekeeping, laundry, plant related, and social service cost centers. The Non-Personnel Operating Cost Component of the Final Rate is the allowable non-personnel operating cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D5 Fixed Cost Component: This component includes the interest, depreciation, amortization, long-term rent/lease payments, personal property tax, real estate tax, and other fixed costs. The Fixed Cost Component of the Final Rate is the allowable fixed cost per day as computed for the ICF/MR provider's most recent cost report period.

31-008.06D6 ICF/MR Revenue Tax Cost Component: This component includes the allowable ICF/MR revenue tax, computed on a per diem basis as the ICF/MR revenue tax based on State Fiscal Year 2007-08 net revenue divided by State Fiscal Year 2007-08 facility resident days. (See 405 NAC 1-003.)

31-008.06E Out-of-State Facilities: The Department pays out-of-state facilities participating in NMAP at a rate established by that state's Medicaid program at the time of the issuance or reissuance of the provider agreement. The rate will not exceed the average per diem being paid to Nebraska non-State-operated facilities for services in a similar care classification. The payment is not subject to any type of adjustment.

31-008.06F Initial Rates for New Providers:

31-008.06F1 Initial Rates for New Providers of ICF/MRs with 16 beds or more: Providers entering the NMAP as a result of a change of ownership will receive rates as follows. The rate in effect at the time of the change in ownership will be paid to the new provider for the remainder of the rate period. For the next rate period, the cost reports for all owners during the report period will be combined. The combined report will be the complete cost report for that facility and will be used for rate determinations and limitation determinations.

Providers entering the NMAP as a result of new construction, a facility re-opening, or a certification change from Nursing Facility to ICF/MR will receive a prospective rate equal to the average prospective rate of all Nebraska non-State-operated facilities of the same care classification. The rate will change at the beginning of a new rate period. The rate will be based on the care class average until the provider's first rate period following participation in the program for one full report period.

31-008.06F2 Initial Interim Rates for New Providers of ICF/MRs with 4-15 Beds: All new providers entering the NMAP will be required to submit a proposed budget covering census, revenues, operating expenses and fixed expenses as detailed on the Medicaid Cost Report. The Department will review and, if necessary, adjust the proposed budget amounts based on reasonableness and allowability. The Department will calculate an initial interim rate based on the adjusted budget amounts. The initial interim rate will be retroactively adjusted based on the provider's actual, audited costs for the rate period, according to 471 NAC 31-008.06C2b.

31-008.07 Depreciation: This subsection replaces Medicare regulations on depreciation in their entirety, except that provisions concerning sale-leaseback and lease-purchase agreement (Medicare's Provider Reimbursement Manual (HIM-15), Section 110) are retained, subject to the following Medicaid depreciation regulations.

At the time of an asset acquisition, the ICF/MR must use the American Hospital Association Estimated Useful Lives of Depreciable Hospital Assets, 2004 edition, to determine the useful life span. In the event that the ICF/MR determines a useful life shorter than a life shown in the tables, the facility must have documentation available to justify the unique circumstances that required the shorter life. In determining the allowable basis for a facility which undergoes a change of ownership or for new construction, see 471 NAC 31-008.05J and 31-008.05K.

31-008.07A Definitions: The following definitions apply to depreciation:

Fair Market Value: The price that the asset would bring by bona fide bargaining between well-informed buyers and sellers at the date of acquisition.

Straight-Line Method: A depreciation method in which the cost or other basis (e.g., fair market value in the case of donated assets) of the asset, less its estimated salvage value, if any, is determined and the balance of the cost is distributed in equal amounts over the assigned useful life of the asset class.

31-008.07B Capitalization Guidelines: Providers must devise and follow a written capitalization policy within the following guidelines. A copy of the policy must be available upon request by the Department.

31-008.07B1 Capitalization Threshold: The capitalization threshold is a pre-determined amount at which asset purchases must be capitalized rather than expensed. Each provider determines the capitalization threshold for its facility, but the threshold amount must be at least $100 and no greater than $5,000.

31-008.07B2 Acquisitions: If a depreciable asset has at the time of its acquisition an estimated useful life of at least 2 years and a historical cost equal to or exceeding the capitalization threshold, its cost must be capitalized and written off ratably over the estimated useful life of the asset. If a depreciable asset has a historical cost less than the capitalization threshold, or if the asset has a useful life of less than 2 years, its cost is allowable in the year it is acquired.

31-008.07B3 Acquisitions Under $100: Acquisitions after July 1, 2004 with a per unit cost of less than $100 cannot be depreciated. Costs of these items are to be included in the applicable operating cost category on the Cost Report in the current period.

Examples:

Item	Per Item Cost	Account
Toaster	$38	Dietary Supplies
30 Wastebaskets	$22 ($660 total)	Housekeeping Supplies
Calculator (bookkeeper)	$95	Administration Supplies
Pill Crusher	$62	Nursing Supplies
Wrench Set	$77	Plant Related Supplies

31-008.07B4 Integrated System Purchases: When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. For example, an integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.

31-008.07B5 Multiple Items: Items that have a stand-alone functional capability may be considered on an item-by-item basis or as an aggregate single purchase. Each provider's capitalization policy should describe how the provider elects to treat these items. For example, depending on the provider's capitalization policy, stand-alone office furniture (e.g., chairs, freestanding desks) with per item costs that are under the capitalization threshold may be expensed as numerous single items, or the total cost of all items may be capitalized as an aggregate single purchase.

31-008.07B6 Non-Capital Purchases: Purchases of equipment and furnishings over $100 per item and under the provider's capitalization threshold are included in the Plant Related cost category on the Cost Report in the current period.

31-008.07B7 Betterments and Improvements: Betterments and improvements extend the life, increase the productivity, or significantly improve the safety (e.g., asbestos removal) of an asset as opposed to repairs and maintenance which either restore the asset to, or maintain it at, its normal or expected service life. Repair and maintenance costs are always allowed in the current accounting period.

For the costs of betterments and improvements, the guidelines in 471 NAC 31-008.07B1 through 31-008.07B6 must be followed. For example, if the cost of a betterment or improvement to an asset is equal to or exceeds the capitalization threshold and the estimated useful life of the asset is extended beyond its original estimated useful life by at least 2 years, or if the productivity of the asset is increased significantly over its original productivity, or the safety of the asset is increased significantly, then this cost must be capitalized and written off ratably over the remaining estimated useful life of the asset as modified by the betterment or improvement.

31-008.07B8 The following examples show the cost report treatment of various purchases under two different capitalization policies:

Example A
Provider A's written capitalization policy has a $5,000 threshold for single item purchases. Purchases of multiple items are treated on an item-by-item basis.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Plant Related – as per item cost is less than $5,000
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Plant Related
Range/Oven	$4,900	Plant Related
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Plant Related – as per item cost is less than $5,000
3 Cubicle Walls & Desktop for an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Plant Related – as total cost of integrated system is less than $5,000

Example B
Provider B's written capitalization policy has a $1,500 threshold for single item purchases. Multiple item purchases are treated as an aggregate single purchase.

Item	Per Item Cost	Cost Report Category
5 Computers	$1,750 (total = $8,750)	Capitalize & Depreciate
Boiler	$12,500	Capitalize & Depreciate
TV for Day Room	$1,300	Plant Related
Lawn Mower	$2,500	Capitalize & Depreciate
Range/Oven	$4,900	Capitalize & Depreciate
Resident Room Carpet	$800	Plant Related
10 Resident Beds	$700 (total = $7,000)	Capitalize & Depreciate – as aggregate cost of $7,000 is more than $1,500
3 Cubicle Walls & Desktop For an Office Cubicle	$300 (total = $900) $700 (total = $1,600)	Capitalize & Depreciate – as cost of integrated system is greater than $1,500

31-008.07C Buildings and Equipment: An appropriate allowance for depreciation on buildings and equipment is an allowable cost. The depreciation must be:

1. Identifiable and recorded in the provider's accounting records;
2. Based on book value of the asset(s) in use before July 1, 1976. Book value for these purposes is defined as cost less depreciation allowed or allowable per American Hospital Association or Internal Revenue Service guidelines; 008.05J and 31-008.05K);

3. Based on the lesser of cost or fair market value at the time of purchase for a facility purchased or constructed after June 30, 1976. The basis for facility purchases or new construction may be subject to limitation (see 471 NAC 31-008.05J and K)
4. Based on the fair market value at the time of donation in case of donated assets. Depreciation on donated assets must be funded in order to be allowed; this requires that money be segregated and specifically dedicated for the purpose of replacing the asset; and
5. Prorated over the estimated useful life of the asset using the straight-line method of depreciation.

31-008.07D Purchase of an Existing Facility: Unless there is a comprehensive appraisal by a Member of the Appraisal Institute (MAI), the Department uses the following guidelines to determine a reasonable allocation of the allowable basis to furniture and equipment for which "component" depreciation may be claimed.

Classification	Variable for Under 40 Beds	Basic Cost Bases For 40 to 75 Beds	Variable for Over 75 Beds
Moveable furniture	$1,000 per bed	$1,000 per bed	$1,000 per bed
Dietary equipment	2 1/2% decrease to "Basic" for each bed	$25,000	1% increase to "Basic" for each bed
Laundry equipment	"	$20,000	"
Heating equipment	"	$10,000	"
Air Cond. equipment	"	$10,000	"

31-008.07E Recapture of Depreciation: Depreciation in 471 NAC 31-008.07E refers to real property only. An ICF/MR which is sold for a profit and has received NMAP payments for depreciation must refund to the Department the lower of:

1. The amount of depreciation allowed and paid by the Department between October 17, 1977, and the time of sale of the property; or
2. The product of the ratio of depreciation paid by the Department since October 17, 1977, to the total depreciation accumulated by the facility (adjusted to total allowable depreciation under the straight-line method, if any other method has been used) times the difference in the sale price of the property over the book value of the assets sold.

$$\frac{\text{Depreciation Paid by State}}{\text{Accumulated Depreciation}} \times (\text{Sales Price} - \text{Book Value})$$

If the recapture of depreciation in any or all years before August 1, 1982, would have resulted in additional return on equity as allowed by the reimbursement plan then in effect, the amount of return on equity must be offset against the amount of recapture.

Examples:	Data	
1.	Original Cost of Facility	$400,000
2.	Total Depreciation (S.L.) to date	$100,000
3.	Book Value of Facility (1-2)	$300,000
4.	Depreciation Paid Under Medicaid	$ 35,000
5.	Ratio of Depreciation Paid to Total Depreciation (4/2)	35%

Example A

Facility Sold For	$500,000
Difference in the Sale Price Over the Book Value	$200,000 ($500,000 - $300,000)
Medicaid Apportionment (35% X $200,000)	$70,000

The amount of depreciation recaptured on gain is $35,000, the amount of depreciation previously paid under NMAP.

Example B

Facility Sold For	$350,000
Difference in the Sales Price Over the Book Value	$ 50,000
Medicaid Apportionment (35% X $50,000)	$ 17,500

The amount of depreciation recaptured on gain is $17,500, which is the ratio of depreciation paid under NMAP for Medicaid clients ($35,000) to total depreciation accumulated ($100,000) times the amount of gain ($50,000) on the disposition of real property.

31-008.07F Other Gains and Losses on Disposition of Assets: Losses on the sale of real property are not recognized under NMAP. Losses on the disposal of replaced building components that have been specifically identified in the nursing facility's depreciation schedule since acquisition will be included in the allowable fixed cost for the report period. Gains/losses on personal property will be reduced from/included in allowable fixed costs for the report period. Gains in excess of the other allowable fixed costs will result in a negative fixed cost component of the facility's rate.

31-008.07G Sale or Transfer of Corporate Stock: Where the existing corporation continues after the sale or transfer of corporate stock, the depreciable basis of assets used under the program will be that of the then existing corporation. No revaluation of assets is allowed when only an acquisition of stock is involved.

31-008.08 Reporting Requirements and Record Retention: Providers must submit cost and statistical data on Form FA-66, "Report of Long Term Care Facilities for Reimbursement" (see 471-000-41). Data must be compiled on the basis of generally accepted accounting principles and the accrual method of accounting for the report period. If conflicts occur between generally accepted accounting principles and requirements of this regulation, the requirements of this regulation prevail. Financial and statistical records for the period covered by the cost report must be accurate and sufficiently detailed to substantiate the data reported. All records must be readily available upon request by the Department for verification of the reported data. If records are not accurate, sufficiently detailed, or readily available, the Department may correct, reduce, or eliminate data. Providers are notified of changes.

Each facility must complete the required schedules and submit the original, signed Report to the Department within 90 days of the close of the reporting period, when a change in ownership or management occurs, or when terminated from participation in NMAP. Under extenuating circumstances, an extension not to exceed 45 days may be permitted. Requests for extensions must be made in writing before the date the cost report is due.

When a provider fails to file a cost report as due, the Department will suspend payment. At the time the suspension is imposed, the Department will send a letter informing the provider that if a cost report is not filed, all payments made since the end of the cost report period will be deemed overpayments. The provider must maintain levels of care if the Department suspends payment.

If the provider takes no action to comply with the obligation, the Department may refer the case for legal action.

If a cost report has not been filed, the sum of the following is due:

1. All interim payments made during the rate period to which the cost report applies;
2. All interim payments made subsequent to the accounting rate period to which the cost report applies; and
3. Costs incurred by the Department in attempting to secure reports and payments.

If the provider later submits an acceptable cost report, the Department will undertake the necessary audit activities. Providers will receive all funds due them reflected under the properly submitted cost reports less any costs incurred by the Department as a result of late filing.

Providers must retain financial records, supporting documents, statistical records, and all other pertinent records related to the cost report for a minimum of five years after the end of the report period or until an audit started within the five years is finalized, whichever is later. Records relating to the acquisition and disposal of fixed assets must be retained for a minimum of five years after the assets are no longer in use by the provider. The Department retains all cost reports for at least five years after receipt from the provider.

Facilities that provide any services other than certified ICF/MR services must report costs separately, based on separate cost center records. As an alternative to separate cost center records and for shared costs, the provider may use a reasonable allocation basis documented with the appropriate statistics. All allocation bases must be approved by the Department before the report period. Any Medicare certified facility must not report costs for a level of care to the Department which have been reported for a different level of care on a Medicare cost report.

31-008.08A Disclosure of Cost Reports: Cost reports for all report periods ending October 30, 1990, or thereafter, are available for public inspection by making a written request to the Department of Health and Human Services Audit Unit. The request must include the name (including an individual to contact), address, and telephone number of the individual or organization making the request; the ICF/MR name, location, and report period for the cost report requested; and directions for handling the request (review the reports at the Department's Lincoln State Office Building address; pick up copies from the Department; or mail copies). The total fee, $5.00 for each report to be copied and an additional $2.50 for each report to be mailed, must accompany the request. The ICF/MR will receive a copy of a request to inspect its cost report.

31-008.09 Audits: The Department will perform at least one desk audit and may perform subsequent desk audits and/or a periodic field audit of each cost report. Selection of subsequent desk audits and field audits will be made as determined necessary by the Department to maintain the integrity of the Nebraska Medical Assistance Program. The Department may retain an outside independent public accounting firm, licensed to do business in Nebraska or the state where the financial records are maintained, to perform the audits. Audit reports must be completed on all field audits and desk audits. All audit reports will be retained by the Department for at least three years following the completion and finalization of the audit.

An initial desk audit will be completed on all cost reports. Payment rates are determined after the initial desk audit is completed.

All cost reports, including those previously desk audited but excluding those previously field audited, are subject to subsequent desk audits. The primary period(s) and subject(s) to be desk-audited are indicated in a notification letter sent to the provider to initiate a subsequent desk audit. The provider must deliver copies of schedules, summaries, or other records requested by the Department as part of any desk audit.

All cost reports, including those previously desk-audited but excluding those previously field-audited, are subject to field audit by the Department. The primary period(s) to be field-audited are indicated in a confirmation letter, which is mailed to the facility before the start of the field work. A field audit may be expanded to include any period otherwise open for field audit. The scope of each field audit will be determined by the Department. The provider must deliver to the site of the field audit, or an alternative site agreed to by the provider and the Department, any records requested by the Department as part of a field audit.

The Department may not initiate an audit:

1. More than five years after the end of the report period; or
2. On a cost report which has been previously field-audited.

This does not preclude the Department from reopening an audit in accordance with 471 NAC 31-008.13 #1 or initiating an audit in response to a reopening in accordance with 471 NAC 31-008.13 #2 or when grounds exist to suspect that fraud or abuse has occurred.

31-008.10 Settlement and Rate Adjustments: When an audit has been completed on a cost report, the Department will determine if an adjustment to the rate is required; if necessary, a settlement amount is determined. Payment or arrangements for payment of the settlement amount, by either the Department or the provider, must be made within 45 days of the settlement notice unless an administrative appeal filed within the appeal period is also filed within the 45-day repayment period. Administrative appeals filed after the 45-day payment period will not stay repayment of the settlement amount. The filing of an administrative appeal will not stay repayments to the Department for audit adjustments not included in the appeal request. If an audit is completed during the applicable rate period, the Department will adjust the rate for payments made after the audit completion.

The Department will determine a final adjustment to the rate and settlement amount after the audit is final and all appeal options have been exhausted. Payment for any final settlement must be made within 30 days. If payment is not made, the Department will immediately begin recovery from future facility payments until the amount due is recovered.

The Department will report an overpayment to the federal government on the appropriate form no later than the second quarter following the quarter in which the overpayment was found.

31-008.11 Penalties: Under federal law, the penalty for making a false statement or misrepresentation of a material fact in any application for Medicaid payments and for soliciting, offering, or accepting kickbacks or bribes (including the rebate of a portion of a fee or charge for a patient referral) is imprisonment up to five years, a fine of $25,000, or both. Similarly, making a false statement of material fact about conditions or operations of any institution is a felony punishable by up to five years imprisonment, a fine of not more than $25,000, or both.

31-008.12 Appeal Process: Final administrative decision or inaction in the allowable cost determination process is subject to administrative appeal. The provider may request an appeal in writing from the Director of the Department within 90 days of the decision or inaction. The request for an appeal must include identification of the specific adjustments or determinations being appealed and basis and/or explanation of each item. See 471 NAC 2-003 and 465 NAC 2-006 for guidelines for appeals and fair hearings.

After the Director issues a determination in regard to the administrative appeal, the Department will notify the facility of the final settlement amount. Repayment of the settlement amount must be made within 30 days of the date of the letter of notification.

31-008.13 Administrative Finality: Administrative decision or inaction in the allowable cost determination process for any provider, which is otherwise final, may be reopened by the Department within three years of the date of notice of the decision or inaction.

"Reopening" means an action taken by the Director of the Division of Medicaid and Long-Term Care to reexamine or question the correctness of a determination or decision that is otherwise final. The Director is the sole authority in deciding whether to reopen. The action may be taken:

1. On the initiative of the Department within the three-year period;
2. In response to a written request from a provider or other entity within the three-year period. Whether the Director will reopen a determination, which is otherwise final, depends on whether new and material evidence has been submitted, a clear and obvious error has been made, or the determination is found to be inconsistent with the law, regulations and rulings, or general instructions; or
3. Any time fraud or abuse is suspected.

A provider does not have the right to appeal a finding by the Director that a reopening or correction of a determination or decision is not warranted.

31-008.14 Sanctions: Failure to comply with any repayment provisions will result in immediate suspension of payments as outlined in 471 NAC 2-002, except that the Department is not required to give 30 days notice.

31-008.15 Change of Holder of Provider Agreement: A holder of a provider agreement receiving payments under this section must notify the Department 60 days before any change or termination regarding the holder of the provider agreement. If any known settlement is due the Department by that provider, payment must be made immediately. If the provider is subject to recapture of depreciation on the anticipated sale and/or if an audit is in process, the provider will be required to provide a guarantee of repayment of the Department's estimated settlement either by payment of that amount to the Department, providing evidence that another provider receiving payments under this section has assumed liability, or by surety bond for payment. All estimated or final amounts, regardless of appeal status, must be paid before the transfer of ownership.

The Department will not enter into a provider agreement with a new provider if there is an unpaid settlement payable to the Department by a prior provider of services at the same facility unless the new provider has assumed liability for the unpaid amount. Parties to a facility provider change may receive information about unpaid settlement amounts owed to the Department by making a written request.

The State has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security Act.

APR - 2 2010

Approved _____

JUL -- 2003

Effective _____

OS Notification

State/Title/Plan Number: Neb 09-05

Type of Action: SPA Approval

Required Date for State Notification: 04/05/2010

Fiscal Impact: FFY 10 $760,000 FFY 11 $3,900,000

Number of Services Provided by Enhanced Coverage, Benefits or Retained Enrollment: 0

Number of Potential Newly Eligible People: 0
or
Eligibility Simplification: No

Provider Payment Increase: Yes **or Decrease:** No

Delivery System Innovation: No

Number of People Losing Medicaid Eligibility: 0

Reduces Benefits: No

Detail:

For nursing facility services, this SPA updates the State plan to define the current rate period of July 1, 2009 through June 30, 2010, to specify the current base cost period (July 1, 2007 through June 30, 2008) used to calculate rates, to update the maximum compensation levels of administrators, owners, and directly related parties, to set the fixed cost maximum per diem to $27, to specify an inflation factor of 0.78%, and to update provisions of setting rates for new providers by one year.

For ICF/MR services, this SPA splits the rate setting methodology for non-state-operated facilities into two parts – one methodology for large facilities with 16 or more beds and one methodology for small facilities with 4-15 beds. For large facilities, this SPA updates the State plan to define the current rate period of July 1, 2009 through June 30, 2010, to specify the current base cost period (July 1, 2007 through June 30, 2008) used to calculate rates, to update the maximum compensation levels of administrators, owners, and directly related parties, to specify an inflation factor of 5.0%, and to update provisions of the ICF/MR Revenue Tax Cost Component by one year. For small facilities, this SPA adds a retrospective rate setting methodology that generally follows the methodology for large facilities except that interim rates are reconciled to actual costs at the end of the cost reporting period, that non-fixed costs are not subject to the 85% minimum occupancy requirement, that facilities are exempt from Certificate of Need requirements, and that initial rates for new providers will be negotiated based on a proposed budget.

Other Considerations:
This plan amendment has not generated significant outside interest and we do not recommend the Secretary contact the governor.

This OSN has been reviewed in the context of the ARRA and approval of the OSN is not in violation of ARRA provisions.

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National Institutional Reimbursement Team