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State/Territory Name: Wyoming

State Plan Amendment (SPA) #: 25-0007

This file contains the following documents in the order listed:

1) Approval Letter
2) Companion Letter
3) CMS 179 Form/Summary Form (with 179-like data)
4) 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

Financial Management Group

November 5, 2026

Jesse Springer
Interim State Medicaid Agent
Division of Healthcare Financing
122 West 25th, St. 4 West
Cheyenne, WY 82002

RE: TN 25-0007

Dear Agent Springer,

The Centers for Medicare & Medicaid Services (CMS) has reviewed the proposed Wyoming state plan amendment (SPA) to Attachment 4.19-D WY 25-0007, which was submitted to CMS on September 22nd, 2025. This plan amendment proposes to implement Patient Driven Payment Methodology (PDPM) for nursing facilities, update rate-setting and communication procedures, and clarify provider requirements.

We reviewed your SPA submission for compliance with statutory requirements, including in sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903 as it relates to the identification of an adequate source for the non-federal share of expenditures under the plan, as required by 1902(a)(2), of the Social Security Act and the applicable implementing Federal regulations.

Based upon the information provided by the state, we have approved the amendment with an effective date of July 1, 2025. We are enclosing the approved CMS-179 and a copy of the new state plan pages.

If you have any additional questions or need further assistance, please contact Sudev Varma at via email at sudev.varma@cms.hhs.gov

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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

Financial Management Group

Jesse Springer
Interim State Medicaid Agent
Division of Healthcare Financing
122 West 25th, St. 4 West
Cheyenne, WY 82002

RE: Payment Methodologies for Out-of-State Providers in Attachment 4.19-D

Dear Agent Springer,

The Centers for Medicare & Medicaid Services (CMS) is providing this letter as a companion to the approval of SPA which amends the State Plan to implement the Patient Driven Payment Methodology (PDPM) for nursing facilities, update rate-setting and communication procedures, and clarify provider requirements.

It appears that some of the previously approved payment methodologies that pay out-of-state providers differently (noted in "same page" review) may be problematic in light of the D.C. Circuit opinion in *Asante v. Kennedy*, No. 23-5055 (D.C. Cir. 2025), petition for cert. denied (U.S. Mar. 23, 2026) (No. 25361). By approving the corresponding SPA, CMS is expressly not approving any payment methodologies that would violate *Asante*. At this time, CMS will not take enforcement action against the state over such payment methodologies provided that the state does not implement such methodologies in a manner that conflicts with *Asante*. CMS is currently exploring options for how to proceed with this issue, which may include rulemaking.

If you have any additional questions or need further assistance, please contact Sudev Varma at 301-448-3915 or via email at sudev.varma@cms.hhs.gov.

Sincerely,

[redacted]

Rory Howe
Director
Financial Management Group

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: 25 — 0007

2. STATE: WY

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

TO: CENTER DIRECTOR
CENTERS FOR MEDICAID & CHIP SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
7/1/2025

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.40

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2025 $ 0
b. FFY 2026 $ 0

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 4.19D Pages 1 - 32 29

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
4.19D Pages 1- 43 (Supersedes TN# WY-16-0009)

9. SUBJECT OF AMENDMENT
Amendment to implement the Patient Driven Payment Methodology (PDPM) for nursing facilities, update rate-setting and communication procedures, and clarify provider requirements.

10. 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:

11. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

12. TYPED NAME
Jesse Springer

13. TITLE
Interim State Medicaid Agent

14. DATE SUBMITTED

15. RETURN TO
Jesse Springer
Interim State Medicaid Agent
Division of Healthcare Financing
122 West 25th, St. 4 West
Cheyenne, WY 82002

CC:

FOR CMS USE ONLY

16. DATE RECEIVED
September 22, 2025

17. DATE APPROVED
11/5/2026

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2025

19. SIGNATURE OF APPROVING OFFICIAL
[redacted]

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director of the Financial Management Group

22. REMARKS

10/28/26: Permission to make Pen and Ink change in Block 7 was granted by state

Section 1. Authority.

This attachment is prepared and submitted to the Centers for Medicare & Medicaid Services for approval as part of the Wyoming Medicaid State Plan.

Section 2. Purpose and Applicability.

(a) This Chapter applies to payments to and assessments of nursing facilities that provide nursing facility services to clients.

(b) The Department may issue manuals and bulletins to interpret the provisions of this Chapter. The contents of manuals and bulletins are subordinate to the provisions of this Chapter.

Section 3. Definitions.

(a) Except as otherwise specified in the Wyoming Department of Health, Medicaid Rules, Chapter 1 or defined in this Chapter, the terminology used herein has the standard meaning used in healthcare, Medicaid, and Medicare.

(b) "Chapter" – a chapter in the Wyoming Department of Health, Medicaid Rules.

Section 4. General Provisions.

(a) An allowable cost must be reasonable, ordinary, necessary, and related to patient care.

(b) A nursing facility must deliver quality healthcare efficiently and economically.

(c) Except as otherwise specified in this Chapter, the Department determines per diem rates using the methodology set forth in the Medicare Provider Reimbursement Manual ("PRM") and the CMS instructions for administering the PRM. The PRM and the CMS instructions are incorporated by reference and are available from the CMS.

(d) The Department calculates per diem rates for nursing facilities using a combination of a cost-based system and a fixed price system.

Section 5. Cost Report.

(a) Deadline. A certified cost report for each nursing facility must be submitted to the Department by the end of the fifth month following the nursing facility's fiscal year end.

(i) The Department may grant one thirty-day extension of the submission deadline if a nursing facility provides good cause for the extension in writing before its submission deadline.

(ii) A cost report is deemed complete when the Department receives the certified cost report with all of the required documentation.

(iii) If the Department does not receive a nursing facility's complete cost report within ten days after the deadline, the Department shall reduce the nursing facility's per diem rate by 25% until the nursing facility submits its complete cost report or the Department suspends payment to the nursing facility.

(iv) If the Department does not receive a nursing facility's complete cost report within sixty days after the deadline, the Department shall suspend all Medicaid payments to the nursing facility until the Department receives a complete cost report from the nursing facility.

(v) The Department may pay the nursing facility the suspended payments without interest.

(vi) Reduction and suspension of per diem rates do not affect any of the Department's other rights or remedies.

(vii) A nursing facility that closes or changes ownership is not required to submit a cost report if that cost report will not be used to calculate a rate.

(b) Attachments. The nursing facility must attach a copy of each of the following documents in which it is a party to the cost report.

(i) Contracts involving the purchase of a facility or equipment during the last seven years, unless previously submitted;

(ii) Contracts with an owner or other entity related to the nursing facility, unless previously submitted;

(iii) Leases of real or personal property, unless previously submitted;

(iv) Management contracts, unless previously submitted;

(v) Mortgages or loan agreements, unless previously submitted;

(vi) Working trial balance used to prepare the cost report with line number tracing notations or similar identifications;

(vii) Audit, review, or compilation statements prepared by an independent accountant that includes the nursing facility costs or allocation of costs to the nursing facility, including disclosure statements and management letters or SEC 10-K forms;

(viii) Home office cost statements;

(ix) Current Medicare cost report;

(x) Wyoming Financial Report for Long Term Care, a supplemental cost reporting form specific to the Medicaid program; and

(xi) Any other documents requested in writing by the Department that relates to the provision of services, the submission of claims for payment, or a nursing facility's cost reports.

(c) Cost reporting method. A nursing facility may change its cost reporting method only if, prior to the end of the cost reporting period, it requests the change in writing, and the Department approves the change. The Department must not withhold approval if the change can reasonably be expected to result in more accurate reporting.

(d) Fiscal period. A nursing facility must use the same fiscal period as it uses for reporting Medicare costs.

(i) If a nursing facility is not certified by Medicare, it must use the same period it uses for federal income tax reporting.

(ii) A cost reporting period of less than six months must not be used to calculate a nursing facility's rate.

(e) Setting per diem rate. The Department will set a nursing facility's per diem rate within ninety days of the Department's receipt of a complete cost report

(f) Certification of cost reports.

(i) Misrepresentation or falsification of any information contained in a cost report may be punishable by a fine and/or imprisonment under state or federal law.

(ii) Each cost report must include the following certification signed by an authorized agent of the nursing facility:

> I certify that I have reviewed the foregoing cost report for the fiscal year beginning _____, 20___, and ending _____, 20___, including all required documentation and, to the best of my knowledge and belief, it is an accurate and complete report prepared from the books and records of the nursing facility in accordance with standard accounting principles and applicable instructions, except as specifically noted and explained in the cost report. Additionally, an accurate copy of all required documentation is attached to the cost report.
>
> _____ _____ _____
> Signature Title Date
>
> _____
> Printed name

Section 6. Joint Use of Resources.

(a) Each nursing facility must keep its revenues, expenses, and statistical and financial records separate and clearly identified. If a nursing facility does not comply with this rule, commingled costs are disallowed for purposes of all involved nursing facility's per diem rate.

(b) A nursing facility must allocate pooled costs reasonably and in conformance with GAAP. A pooled cost is allowable only to the extent that the pooled cost is incurred in providing patient-related services and the nursing facility can demonstrate that pooled cost improves efficiency, economy, or quality of care. Allowable pooled costs may be reported as an operating cost.

(c) Direct patient service costs incurred by multiple nursing facility organizations may be reported in the health care component if the service was rendered to the client at the nursing facility and is separately identified, rather than allocated, in the provider's accounting records. Patient service costs which do not meet these criteria must be reported in the operating cost component.

Section 7. Per Diem Rate for New Nursing Facilities and When Ownership Changes

(a) New nursing facility. A new nursing facility is a newly constructed nursing facility that did not previously exist, a newly designated portion of a hospital which was not previously designated as a nursing facility, or an existing facility which was not previously certified. An addition to a certified nursing facility is not a "new facility." An existing nursing facility that constructs a new building to move into is not a new nursing facility but the new building may be subject to a re-age adjustment.

(i) A new nursing facility per diem rate is calculated as follows:

(A) Healthcare portion of rate. The same starting price as applied to other nursing facilities with a quarterly case mix adjustment using the new nursing facility's case mix scores will be applied. If the nursing facility does not have qualifying case mix data at the time per diem rates are calculated, the healthcare portion is calculated using the statewide Medicaid average case mix score from the prior quarter.

(B) Capital portion of rate. A property rental rate based on the age of the building is applied. If the age cannot be determined at the time of rate setting or if the nursing facility does not supply requested data to calculate the age of the property, a property rental rate based on a 40 year old building is applied. This rate will not be adjusted retrospectively if a nursing facility supplies the requested data after the rate setting period. The rate will be adjusted at the next rate setting quarter if the nursing facility timely supplies the requested data.

(C) Exempt portion of rate. The statewide average exempt portion from the previous quarter is applied.

(D) Operating portion of rate. The same fixed price applied to other

nursing facilities that quarter is applied.

(ii) A new nursing facility's rate will be calculated in this manner until the nursing facility has a qualifying cost report that has been audited. At that time, the qualifying cost report will be used to set its rate effective with the July 1 rate cycle.

(b) Change of Ownership.

(i) When a nursing facility changes ownership, its per diem rate is calculated as follows:

(A) Healthcare rate. The new owner will receive the same starting price as all other facilities with a quarterly case mix adjustment using the new owner's case mix scores. If the new owner does not have the qualifying case mix data at the time per diem rates are calculated, the healthcare costs will be calculated using the prior owner's Medicaid average case mix score from the most recently available quarter.

(B) Capital rate. The new owner assumes the building age used for the property rental rate from the prior owner.

(C) Exempt rate. The new owner will assume the exempt portion of the per diem rate using the most currently available audited data from the prior owner.

(D) Operating rate. The same fixed price applied to other nursing facilities that quarter is applied.

(ii) The rate will be calculated in this manner until the nursing facility has a qualifying cost report that has been audited. At that time, the qualifying cost report will be used to set its rate effective with the July 1 rate cycle.

(iii) Record keeping. The former owner is responsible for maintaining all medical and financial records for one year after the date of the change of ownership. If the nursing facility is involved in an audit or administrative or judicial proceedings which require access to such records, the former owner must maintain the records for one year after completion of all proceedings, including any applicable appeal periods.

(c) Effective dates of per diem rates. Per diem rates are established prospectively and shall remain in effect from the rate effective date until re-determined pursuant to this rule.

Section 8. Reserve Bed Days.

(a) Medicaid will not pay for reserve bed days.

(b) A nursing facility may not bill a client or the client's family for reserved bed days unless the nursing facility informed the client in writing before the period for which payment is sought of the client's option to personally pay to hold the bed.

Section 9. Cost Categories.

(a) General requirements. Costs are allocated among the following categories: (1) healthcare; (2) capital; (3) exempt; and (4) operating. For purposes of this Chapter, labor costs include the cost of employee benefits and taxes. Supplies used in providing patient-related services include, but are not limited to, those specified in Attachment A.

(b) Healthcare costs. Healthcare costs consist of direct costs of patient-related services rendered within a nursing facility. Healthcare costs are subject to a quarterly case mix acuity adjustment. Healthcare costs include, but are not limited to:

(i) Entering and maintaining medical records;

(ii) Providing social services;

(iii) Providing direct nursing healthcare by:

(A) Registered nurses;

(B) Licensed practical nurses;

(C) Nurse assistants and certified nurse assistants (CNA); and

(D) Contract nurses.

(iv) Payroll taxes and employee benefits associated with the wages above.

(c) Capital costs. Capital costs include, but are not limited to:

(i) Leasehold amortization;

(ii) Rent and lease of real property;

(iii) Depreciation; and

(iv) Interest on loans for real property and personal property.

(d) Exempt costs. Exempt costs include, but are not limited to:

(i) Property taxes. Tax penalties, late fees, and income taxes are not allowable.

(ii) Property insurance. Malpractice, workmen's compensation, and other employee- related insurances are not considered property insurance and are not exempt.

(iii) Fees for CNA classes, texts, and exams.

(e) Operating costs. Operating costs include, but are not limited to:

(i) Administrative and general costs including:

(A) Home office; and

(B) Management fees.

(ii) Physical facility operations;

(iii) Laundry;

(iv) Housekeeping;

(v) Cafeteria;

(vi) Dietary;

(vii) Nurse administration;

(viii) Central services, routine supplies, and non legend drugs;

(ix) Pharmacy consultant;

(x) Activities;

(xi) Payroll taxes and employee benefits associated with the wages above;

(xii) Medical director; and

(xiii) Other costs permitted by federal and state rules and regulations not mentioned in (b), (c), and (d) in this section.

Section 10. Capital Costs.

(a) Depreciation.

(i) The depreciation of a tangible asset is an allowable cost if:

(A) The nursing facility currently uses the asset for patient care;

(B) The asset is available for physical inspection; and

(C) Included in the nursing facility's records.

(ii) Basis. The basis used to calculate depreciation is the historical cost of an asset which is the cost incurred by the present owner in acquiring the asset and preparing it for its use. Generally, such cost includes costs that are capitalized under GAAP. For example, in addition to the purchase price, historical cost includes architectural fees, consulting fees, and related legal fees.

(iii) Method. Depreciation must be reported on the straight-line method.

(iv) Useful life. Useful life is determined in accordance with the most recent edition of Estimated Useful Lives of Depreciable Assets, as incorporated by reference and published by the American Hospital Association.

(v) If a single asset or collection of like assets acquired in quantity, including permanent betterment or improvements, has at the time of acquisition an estimated useful life of at least two years and historical cost of at least the minimum amount utilized by Medicare for cost reporting, the cost must be depreciated over the useful life of the asset.

(vi) Assets that do not qualify for depreciation must be included expenses in the year acquired.

(vii) Donated assets.

(A) Definition. An asset is donated to the extent the nursing facility acquired the asset without paying fair market value in cash, property, or services.

(B) Basis. The basis of donated assets, except for donations from an entity related to the nursing facility, is the asset's fair market value minus the value the nursing facility paid for the asset. If the fair market value of the asset is over $2,000.00, the basis is the lesser of the appraised value and the fair market value. If the donor is related to the nursing facility, the basis is the lesser of the donor's net book value and fair market value.

(C) Cash donations. Cash donations shall be treated as revenue, and not as an offset to expense accounts.

(b) Permanent Financing Interest. Permanent financing interest is financing attendant to the acquisition of patient-related tangible assets.

(i) Allowable cost. Permanent financing interest incurred on patient-related real property, improvements to real property, buildings, building components and equipment is an allowable cost subject to the limitations of this subsection.

(ii) Investment income offset. Allowable interest must be reduced by investment income pursuant to the PRM.

(iii) Cost reporting requirement. Interest expense must be supported by a written loan agreement showing that funds were borrowed, payment of interest and repayment of principal is required, and funds were used to purchase patient-related real property, buildings, building

components, or equipment. The lender, purpose, principal amount, terms, and interest rate must be identifiable in the nursing facility's financial records.

(c) Lease and rental expense. Lease and rental expenses incurred on patient-related real property, buildings, building components, or equipment are an allowable cost subject to the limitations of this section.

(d) Related entities. If a nursing facility rents, leases or purchases patient-related real property, buildings, building components, or equipment from an entity related to the nursing facility, the cost must be adjusted to the actual cost incurred by the related entity.

(e) Amortization of leasehold improvements.

(i) Allowable cost. Lease or rental expenses incurred on patient-related real property, buildings, building components, or equipment are an allowable cost subject to the limitations of this section.

(ii) Amortization of leasehold improvements must be calculated and reported in accordance with GAAP and are a capital cost.

(iii) Amortization of organizational cost must be reported as an operating cost.

Section 11. Working Capital Interest. Working capital interest is patient-related financing other than permanent financing.

(a) Interest on a working capital loan is an allowable cost only if the loan was incurred to provide patient-related services.

(b) Interest on a working capital loan must not exceed the actual reported interest less any investment income revenue.

(c) Interest on a working capital loan must be reported as an operating cost.

Section 12. Cost of Services and Supplies not Included in the Per Diem.

(a) Services and supplies which are not included in the per diem rate include, but are not limited to:

(i) Ambulance services;

(ii) Audiology services;

(iii) Barber and beauty shop services other than routine personal hygiene items and services;

(iv) Cigarettes, cigars, pipes and tobacco;

(v) Clothing;

(vi) Cosmetics;

(vii) Dental services (unless under purchase for service contract);

(viii) Dry cleaning;

(ix) Eye examinations and other optical supplies and services;

(x) Hearing aids;

(xi) Hospital services;

(xii) Laboratory services;

(xiii) Orthotic services;

(xiv) Physician services;

(xv) Podiatry services;

(xvi) Prosthetic devices; and

(xvii) Customized wheelchairs that are fitted or fabricated to a specific individual and cannot be used by any other person, and electric wheelchairs.

(b) The cost of services and supplies not included in the per diem rate must be removed from patient-related costs.

(c) Costs not related to patient care are costs that are not appropriate or necessary and proper in developing and maintaining the operation of patient care facilities and activities. Costs which are not necessary may include, but are not limited to, costs that are not usual, common, and accepted occurrences in the field of the provider's activity.

(d) The method of removal depends on a provider's accounting and other records. If a provider has adequate segregation in accounting records, such adjustment must be based on the cost of services or supplies not included in the per diem rate. If a provider does not maintain adequate cost segregation or if such accounts cannot reasonably be subjected to normal audit procedures, then the related revenue must be used as an adjustment to patient expense, provided the related revenue amount is reasonably equal to or greater than cost. If these conditions are not met, the entire group of aggregated ancillary or other revenue accounts, or aggregated ancillary or other cost accounts, if greater, must be used as an offset to patient expenses.

Section 13. Per Diem Rate Period.

(a) A nursing facility's per diem rate is effective on July 1 of each year and may be adjusted quarterly in accordance with its acuity case mix.

(b) A per diem rate is in effect until the Department sets a new per diem rate which, in addition to a quarterly acuity case mix adjustment, may be the result of a desk review, field audit, change in federal or state law that causes an increase in healthcare costs, or legislative budget change.

(c) The data used to calculate the per diem rate effective each July 1 is from the cost reporting period that ended two calendar years prior.

(d) The Department will notify nursing facilities of the per diem rate.

(e) If the Department sets an interim per diem rate, any amounts the Department paid which exceed the final per diem rate are overpayments and recoverable by the Department. If the interim per diem rate is less than the final per diem rate, the Department will pay the difference to the nursing facility within sixty days.

(f) For any nursing facility operated under Public Law 93-638 status, payment is a per diem rate established and updated to 75 percent of the annual OMB rate from the applicable year. Nursing facilities operated under Public Law 93-638 must still submit a cost report unless the Department notifies the nursing facility that it is no longer necessary.

Section 14. Creation of Database.

(a) Each year the Department will create a database from each nursing facility's cost report used to compute the nursing facility's most recent per diem rate.

(b) The database will separate costs from reviewed or audited cost reports into the categories for (1) healthcare costs; (2) capital costs; (3) exempt costs; and (4) operating costs.

(c) Nursing facilities will be grouped by bed range group and into ranges based on the number of licensed beds. Costs will also be grouped by these same ranges.

Section 15. Price and Rate Setting

(a) Payment is a combination of a prospective fixed price system and a cost-based system with the healthcare costs subject to an acuity adjustment. The budget will be used to set the cost and price based rates as follows:

(i) Property Price. The first step of the model is to determine the reimbursement necessary to fund the price-based property rental rate system.

(ii) Exempt Cost Per Diem. The second step of the model determines the amount necessary to fund the exempt costs.

(iii) Healthcare and Operating Prices. The balance of the model will be used to fund healthcare and operating categories. The balance of the model will be allocated between the operating and health care categories based on the statewide total percentage of audited or desk reviewed costs classified to these categories.

(A) The operating price will be the same price for all nursing facilities regardless of their cost.

(B) The healthcare price will begin with the same price to all nursing facilities, regardless of their cost. Each nursing facility's starting price will be further adjusted up or down based on the nursing facility's case mix acuity score for each quarter.

(b) Per diem rates will be further adjusted by bed range group. Each group will receive a percentage adjustment so the resulting cost coverage averages of each group are within a maximum deviation of 5% of each other.

Section 16. HealthCare Case Mix Acuity Adjustment.

(a) Healthcare prices will be paid using a starting fixed price that is the same for all facilities. The fixed price will be adjusted for each individual nursing facility on a quarterly basis based on each nursing facility's Medicaid case mix index to reflect the case mix of that nursing facility's Medicaid residents in a certain quarter. The case mix adjustment will be calculated by taking the fixed starting price times each nursing facility's weighted average Medicaid case mix index divided by the statewide average Medicaid case mix index for each quarter.

(b) Applicable Case Mix Index (CMI). The Medicaid CMI used in establishing each nursing facility's rate is calculated based on the weighted average assessment for each Medicaid resident in the nursing facility in the prior quarter where an MDS assessment was completed and successfully transmitted to the QIES ASAP system.

(i) The CMI is recalculated quarterly and each nursing facility's healthcare component rate is adjusted accordingly.

(ii) In the event that a nursing facility's Medicaid CMI is zero, the nursing facility's average case mix score from the most recent quarter will be used. If there is no data for the previous quarters, they will receive the statewide average Medicaid case mix index score from the prior quarter.

(c) Minimum Data Set (MDS). A set of screening, clinical, and functional status elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The version of the assessment document used for rate setting is version 3.0. Subsequent versions of the MDS will be evaluated and incorporated into rate setting as necessary.

(d) Case Mix Index (CMI). A numeric score assigned to each nursing facility resident,

based on the resident's physical and mental condition that projects the amount of relative resources needed to provide care to the resident.

(i) The Department will use the Patient Driven Payment Methodology (PDPM) case mix classification methodology. The nursing facility case mix classifications will be used to calculate rates.

(ii) For the July 1, 2015 rate quarter, the case mix weight will use the most current MDS assessment for all Medicaid residents as of April 1, 2015. Beginning with the October 1, 2015 quarter and all subsequent quarters, the case mix weight for each resident of a nursing facility for each prior quarter is based on data from MDS assessments completed for the resident and accepted into the QIES ASAP System and weighted by the number of days the resident assessment was in each case mix classification group.

(A) A default case mix group will be established for cases in which the resident dies or is discharged prior to completion of the resident's initial assessment. The default case mix group and case mix weight for these cases will be designated by the Department.

(B) A default case mix group will also be established for cases in which there is an untimely assessment for the resident. The default case mix group and case mix weight for these cases must be designated by the Department.

(iii) The nursing facility Medicaid case mix average will be determined by multiplying the case mix weight of each Medicaid resident by the number of days the resident was at each particular case mix classification group, and then averaging.

(A) The payment source for a resident assessment is considered to be Medicaid if the assessment is a non-PPS assessment where MDS item A0700 Medicaid Number is submitted with a valid Medicaid number.

(B) State-Wide Average Medicaid Case Mix Index. The simple average of all nursing facilities Medicaid case mix indexes used in establishing the reimbursement limitation each quarter.

(e) Nursing Facility: MDS Reviews**.** The following Minimum Data Set (MDS) reviews will be conducted.

(i) Prior to each rate quarter, the Department will send each nursing facility a preliminary report of its resident roster, a listing of residents' assessments, PDPM Nursing Component classification, number of days for the PDPM classification, case mix index, and payment source. The nursing facility must review the preliminary report and submit missing assessments or corrections to the QIES ASAP system prior to the final rate determination.

(ii) If the Department finds errors in the MDS data that result in an incorrect case mix index, the nursing facility's rate will be retroactively adjusted, for all quarters containing the incorrect assessment, and the Department will determine what amount is due to or from the nursing

facility. This does not include residents who received the default classification due to incomplete or inconsistent MDS data.

Section 17. Real Property Rental Rates.

(a) A nursing facility will be paid a rental rate for the building(s) in which it operates. The property rental rate is paid in lieu of payment for capital costs defined in Section 9. The property rental rate does not reimburse for property taxes and property insurance. Property taxes and property insurance will be paid as an exempt cost as defined in Section 9.

(b) A property rental rate is determined using building age as of July 1, 2015. After the building age is determined, the adjustment is applied to the rate calculation based on the table below.

Age	Rate	Age	Rate	Age	Rate	Age	Rate
0	15.55	11	14.20	22	12.85	33	11.50
1	15.43	12	14.08	23	12.73	34	11.38
2	15.30	13	13.95	24	12.60	35	11.25
3	15.18	14	13.83	25	12.48	36	11.13
4	15.06	15	13.71	26	12.36	37	11.01
5	14.94	16	13.59	27	12.24	38	10.89
6	14.81	17	13.46	28	12.11	39	10.76
7	14.69	18	13.34	29	11.99	40	10.64
8	14.57	19	13.22	30	11.87	40+	10.64
9	14.45	20	13.10	31	11.74		
10	14.32	21	12.97	32	11.62		

(c) The age of a building will increase by one (1) year every July 1, beginning on July 1, 2016.

(d) Annually on July 1, the age of each building age will be further adjusted by the percentage change published in the Marshall Swift Index. The percentage change will be determined using in the "*Annual Cost Changes*" published in the "*Current Building Cost Indexes*" section of the Marshall Swift Valuation service publication, or its successor. The Annual Cost Changes category used will be for the Western Region, Class D, Nursing Home (convalescent hospital) group in the most recent publication available of the *Marshall Swift Index* or its successor at the time of rate setting will be used for the annual rate adjustment.

(e) Age of the building. If a building was assigned an age based on the results of a capital cost survey that was conducted in 2013 and updated in 2015, the assigned age as adjusted in accordance with this section will be used to determine the rental rate for the building.

(f) The rental rate for buildings with an adjusted age greater than forty years will be set as a forty year old building.

(g) Age of Building for New Providers.

(i) The age of a building is determined based on reliable documentation the nursing facility submits to the Department that shows the building's historical construction date, square footage, and costs of material capital additions.

(ii) If the nursing facility does not submit reliable documentation thirty days before the beginning of the next rate adjustment quarter, the building age will be set at forty years. If the nursing facility submits reliable documentation of the building's age, the Department will accordingly adjust the building's age at the next rate adjustment quarter.

(h) The effective age of a building may be adjusted based on major repairs, replacement, remodeling, or renovation to the building.

(i) It is the nursing facility's responsibility to notify the Department within one year of completion of any major repairs, replacement, remodeling or renovation of the building. The notification must be in writing with documented costs, square footage, and any other items needed for the review at least 45 days prior to the next rate adjustment quarter.

(ii) Re-age adjustments will be effective on the first day of the next rate adjustment quarter after the re-age calculation was completed. The re-age adjustment shall not apply retroactively.

(iii) A building will not qualify for a re-age adjustment until all of the costs have been capitalized and the changes to the building are in service.

(iv) The re-age adjustment is calculated using the following formula: $R = 40 \times E / S \times C$, where

R =	Re-age adjustment.	The reduction of age of the facility in years.
E =	Actual expenses for the construction	Expenses related to capitalized assets for fixed assets including landscaping, sidewalks, egresses, retaining walls, and parking lots. The total costs must have been incurred within twenty-four (24) months of the completion of the construction. For larger construction projects or additions, 36 months may be granted at the State's discretion.
S =	Total square footage in the building	Gross square feet including common area at the end of the construction.

C =	The cost of construction for the building in the year the construction was completed.	Source is from costs published by Marshall & Swift Valuation Service or its successor. Costs reflect current construction costs for average Class D Nursing Home (convalescent hospital) using the most current publication. If the publication is late at the time of rate setting, the prior year amount will be inflated forward using the "Annual Cost Changes" figure identified in Section 18 (d).

(v) If the result of this calculation is "R" is equal to or greater than 1.0, the age of the building in years will be reduced by this number, rounded to the nearest whole number for rate setting purposes. In no case will the age be less than zero.

(vi) The beginning age of a building minus the re-age adjustment is the "re-age adjusted building age." This age is used to select the rental rate based on the age of the building.

(i) If at the time the July 1 rates are being calculated using the base year building adjusted to the current rate year results in total property rental rate that is more than 10% of the total allocated budget, the property rental rates will be rebased to a lower amount to shift more funds to the healthcare costs and operating costs.

Section 18. State-Owned Nursing Facilities. Any state-owned nursing facility is subject to this Chapter with the exception of rate and price setting.

(a) State-owned nursing facility data will not be included in the nursing facilities database.

(b) A state-owned nursing facility per diem rate is calculated using either its desk reviewed or audited cost report. Costs are not subject to any cap or maximum rate.

(c) Per diem rates for state owned nursing facilities are calculated by inflating the audited or desk reviewed costs from the midpoint of the nursing facility's cost reporting year to the midpoint of the rate year. Inflated costs will be divided by total patient days to set the state-owned nursing facility per diem rate.

(d) The inflation factor is the Skilled Nursing Facility (SNF) Market Basket as published quarterly by DRI/Global Resources or its successor.

(e) In times of hiring difficulties where the state must use contract staffing or in periods of low occupancy which cause a nursing facility to operate at a significant budget deficit, the Department can increase the state-owned nursing facility per diem rate in accordance with the

distressed nursing facility procedures.

Section 19. Extraordinary Care Clients.

(a) The Department and a nursing facility may negotiate to provide skilled nursing facility services and special equipment and staffing that is medically necessary and preauthorized by the Department, but not included in the services provided by nursing facility's per diem rate. Payment will be the nursing facility's per diem rate, plus the negotiated extraordinary care rate.

(i) The only items that may qualify for an extraordinary care rate are:

(A) Tracheostomy;

(B) Ventilator;

(C) Morbid obesity;

(D) Psychiatric care for clients with significant behaviors that cannot otherwise be safely cared for in a standard nursing facility setting without increased staffing or special accommodations, including clients with significant physical aggression, delirium and/or psychosis; or

(E) Case by case situations where the Department determines a condition requires special care or clinically complex care.

(ii) The Department will negotiate with nursing facilities on a case-by-case basis to determine the extraordinary care rate and billing procedures for an extraordinary care client.

(iii) Prior to negotiations, the nursing facility must submit to the Department:

(A) A treatment plan;

(B) A proposed extraordinary care rate, including relevant financial records and medical records that document the medical necessity for services provided to an extraordinary care client; and

(C) All other specific documentation requested by the Department to process the extraordinary care rate request.

(iv) The Department must reevaluate the condition of an extraordinary care client fifteen days after admission, again thirty days after admission, again ninety days after admission, and every six months thereafter.

(v) The Department must review the extraordinary care client's records annually to determine if renegotiating the extraordinary care rate is necessary to reflect changes in the extraordinary care client's condition.

(b) The extraordinary care rate must not exceed the actual cost of the services provided to the extraordinary care client.

(c) The nursing facility must maintain records of the costs it incurs in furnishing services to each extraordinary care client. Costs related to services furnished to extraordinary care clients, other than nursing facility services, are not allowable costs for purposes of determining the nursing facility's per diem rate.

Section 20. Distressed Facilities.

(a) The Department may pay a contracted rate to a distressed nursing facility. The contracted rate may exceed the nursing facility's per diem rate but must not exceed the lesser of:

(i) The Medicare rate "PDPM Case-Mix Adjusted Federal Rates and Associated Indexes—RURAL" as recorded in the Federal Register; or

(ii) A max percentage cap which must not exceed 200% of the nursing facility's per diem rate.

(b) The Department must consider the criteria below:

(i) Factors:

(A) Financial stability and solvency of the nursing facility;

(B) Occupancy (low occupancy as a percentage of capacity or drops quickly) of the nursing facility;

(C) Whether or not the Department has assumed temporary management of the nursing facility; and

(D) Geographic location of the nursing facility.

(ii) Objectives:

(A) Decrease official and unofficial complaints;

(B) Maintenance or improvement of nursing facility survey results;

(C) Maintenance of a provider network in rural or underserved areas; and

(D) Avoidance of client abandonment by the dissolution or insolvency of the distressed nursing facility.

(c) The Department will negotiate with providers determined to be in distress on an

individual basis to determine whether a contracted rate is appropriate for that nursing facility, using the Department's distressed facility criteria.

(i) Prior to negotiations, a nursing facility must submit to the Department, in the format prescribed by the Department:

(A) All relevant financial records and medical records which demonstrate the distressed status of the facility;

(B) A proposed method of monitoring and building overall census; and

(C) The additional cost the nursing facility will reasonably and necessarily be incurring to maintain required daily operations in compliance with all State and Federal provisions.

(ii) If the Department requests, the nursing facility must furnish additional information to document the distressed status and added costs.

(iii) The contracted rate will be agreed upon by the nursing facility and the Department for the maintenance of daily operations focused on client health and safety. The contracted rate applies to all Medicaid clients in the nursing facility unless otherwise stated.

(iv) The Department may establish monitoring criteria and procedures to determine whether the nursing facility continues to maintain client health and safety.

(v) If the Department determines that the client's health and safety are not being maintained in accordance with State and Federal standards, the Department must suspend the nursing facility's temporary rate contract and work with the Office of Healthcare Licensing and Survey to take appropriate action. The contracted rate will be the rate set for a new owner of a distressed nursing facility Upon expiration of the contracted rate, the nursing facility may request up to an additional six months at the contract rate. The Department may extend the contract rate for up to six additional months or terminate the contract rate. A provider can only request to be designated as a distressed rate and receive the temporary rate 12 months within a 5-year period.

(d) The contract rate is an all inclusive per diem rate for all services and supplies furnished by the nursing facility, except as otherwise specified in this Chapter or the contracted rate agreement.

(e) The contracted rate must not exceed the nursing facility's actual costs.

(f) The Department's refusal to agree to a contracted rate requested by a nursing facility is not an adverse action for purposes of Wyoming Department of Health, Medicaid Rules.

Section 21. Nursing Care Facility Assessment.

(a) Nursing facility adjustment payments to nursing facilities based on the upper

payment limit calculation. The Department will make adjustment payments to nursing facilities as described below.

(i) Adjustment payments will be calculated prospectively on an annual basis to be effective from October 1 through September 30 of each year. The total supplemental payment amount is allocated among eligible nursing facilities based on each provider's proportionate share of total Medicaid-paid resident days. The adjustments will be paid quarterly. A new nursing facility opening during that assessment year will not be included in the program until the next assessment year.

(ii) The quarterly adjustment payments will be due to the providers not later than thirty days after the end of each calendar quarter.

(iii) If a nursing facility changes ownership, beginning at the start of the calendar quarter following the date of the change of ownership, the new owner will collect the adjustment payment that was calculated using the prior owner's data. If a nursing facility changes ownership mid quarter, the adjustment payment goes to whoever owns the nursing facility at the end of the quarter.

(iv) Adjustment payments will be calculated based on Medicaid days paid by the Wyoming Medical Assistance Program.

(A) Wyoming Medicaid days will be collected for the dates of service represented in cost reports ended in the calendar year that precedes the assessment effective each October 1. The Medicaid days will be generated by the Department from their MMIS payment system.

(B) For a new nursing facility that opened prior to the October 1 annual calculation that does not have either a full year cost report or a qualifying cost report, resident days will be determined using more current information and will be annualized.

(v) State owned nursing facilities are exempt from this program.

Section 22. Client's Responsibility. If a client has a patient responsibility, the amounts calculated by the Department must be communicated to the nursing facility and the client. Those assigned amounts must be used each month. No additional charges beyond assigned patient responsibility shall be assigned to the client.

Section 23. Change in Provider Status.

(a) If a nursing facility's participation in the Medicaid program is terminated or suspended for any reason, the it must submit a cost report for the period ending with the effective date of the termination or suspension if that cost report is needed for rate setting. The cost report is due within forty-five days after the date of termination or suspension, regardless of the nursing facility's tax period. The final month's payment due a nursing facility will be withheld until its cost report is filed and the Department has a reasonable time to perform a desk review and field audit of

the cost report and patient funds account.

(b) Change of ownership.

(i) The parties to a transaction involving a change of ownership of a nursing facility must notify the Department in writing of the proposed transaction at least thirty days before the effective date of the change.

(ii) Upon a change of ownership, all parties to the transaction shall have thirty days after the change to complete and sign a representation statement, in written form specified by the Department, which details the persons or entities which have assumed the assets and liabilities of a nursing facility. If a representation statement is not timely submitted, both the original provider and any subsequent provider shall be jointly and severally responsible for all Medicaid liabilities which exist either before or after the change of ownership.

(iii) Once a change of ownership has occurred, the previous owner will no longer be able to bill for dates of service beginning the date of the change in ownership. Rate and assessment letters will not be distributed to a new owner until the new owner completes enrollment, and the Department approves the change.

Section 24. Payment of Out-of-State Provider.

(a) The payment rate for an out-of-state nursing facility providing services to a Wyoming client is the lesser of:

(i) The Medicaid per diem rate the nursing facility receives on July 1 of the rate year for the same or similar services from the most recently available rate for the Medicaid program in the state where the nursing facility is located;

(ii) The average Medicaid day weighted average rate in effect in Wyoming as of July 1 of the rate year that the provider needs a rate calculated; or

(iii) The nursing facility's usual and customary rate.

(b) The average Medicaid day weighted average rate in effect shall be determined by:

(i) Multiplying the number of Medicaid days in each nursing facility by each facility's Medicaid per diem rate;

(ii) Adding the products determined pursuant to (i); and

(iii) Dividing the sum determined pursuant to (ii) by the total number of Medicaid days in the state.

(c) An out-of-state provider need not submit cost reports to the Department.

(d) An out-of-state nursing facility must submit with each claim a certification of the nursing facility's per diem rate under the Medicaid program in the state where the nursing facility is located and the nursing facility's usual and customary charge.

(e) The calculated rate will remain in effect until the following July 1. Out of state nursing facilities are not subject to quarterly case mix acuity adjustments.

Section 25. Record Retention.

(a) In the event of a field audit, the nursing facility must have available at the field audit location one or more knowledgeable persons who can explain the nursing facility's financial records, the accounting and control system, and cost report preparation, including attachments and allocations, to the auditors.

(b) A nursing facility that is unable to satisfy any of the requirements of this Section will be given a written notice of deficiency and have sixty days after the date of the written notice to correct the deficiency. If, at the end of the sixty days, the nursing facility has not corrected the deficiency, the Department shall withhold 25% of the nursing facility's per diem rate for services provided after the sixtieth day. If, after 120 days from the mailing of the written notice of deficiency, the nursing facility has still not corrected the deficiency, the Department shall withhold all Medicaid payments for services provided after that date. Payment will not be released until the Department determines that the nursing facility corrected the deficiency.

Section 26. Repayment of Credit Balance.

(a) A nursing facility must report a credit balance on its cost report.

(b) Annual request. The Department may request the repayment of any credit balance annually. Such request will be made in writing; and

(i) Delivered by a method with delivery confirmation; or

(ii) By a secure online portal that provides delivery confirmation. The provider must repay the credit balance within sixty days from the date of delivery confirmation.

(c) A provider must repay any credit balance within sixty days after the date the credit balance is identified by the Department or the provider.

Section 27. Non-Allowable Costs.

(a) If a field audit or desk review discloses non-allowable costs or costs for services and supplies not included in the per diem rate, the Department will adjust the per diem rate retroactively to the beginning of the applicable rate period, recover any overpayments, and adjust the per diem rate for the remainder of the rate period.

(i) Costs which are not reasonably related to services included in the per diem

rate or which are against public policy, contractual allowances, courtesy discounts, charity allowances, or similar adjustments are adjustments to revenue and are not an allowable cost. Non-allowable costs include, but are not limited to:

(A) Advertising expense (other than help wanted ads and telephone directory expense);

(B) Attorney fees and other costs associated with negotiations, administrative proceedings, or litigation involving the Department, except as specified in a settlement;

(C) Bad debts;

(D) Cost arising from joint use of resources (including central office and pooled cost) not reasonably related to patient care;

(E) Capital costs due solely to changes in ownership;

(F) Costs incurred in transactions with an entity related to the nursing facility by common ownership or control, to the extent that such costs exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere (42 C.F.R. § 413.17);

(G) Costs incurred as a result of enforcement actions taken by the Department pursuant to Chapter 5 in response to nursing facility deficiencies, including costs of directed in-service training, suspended or denied per diem rate payments, reimbursement expenses, transfer costs, and costs relating to state monitoring and/or the appointment of a temporary manager;

(H) Costs not reasonably related to patient care;

(I) Costs associated with ancillary and other services attributable to Medicare Part A or Medicare Part B, including direct and indirect costs:

(I) Ninety percent of these costs are non-allowable costs;

(II) One hundred percent of Medicare bed days are non-allowable costs, and

(III) When determining the capital costs for nursing facilities with occupancy below 90% Medicare days will be computed to reflect Medicare occupancy.

(J) Costs related to the acquisition, establishment, or operation of an in-house pharmacy, other than the reasonable costs of a pharmacy consultant;

(K) Costs related to extraordinary care clients that exceed the per diem rate;

(L) Costs related to hospice services;

(M) Costs (such as legal fees, accounting and administration costs, travel costs, and the costs of feasibility studies) which are related to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any Medicaid payment has been previously made;

(N) Federal income and excess profit taxes;

(O) Fees paid to directors and salaries, wages, and fees paid to non-working officers, employees or consultants;

(P) Fund-raising expenses;

(Q) Interest or penalties on federal or state taxes;

(R) Judgments entered against a nursing facility or settlements entered into by a nursing facility arising out of actions or inactions of the nursing facility's agents or employees, including judgments entered against a nursing facility's agent or employee that a nursing facility pays, or settlements involving the nursing facility's agent or employee that the nursing facility pays;

(S) Life insurance premiums for officers and owners and related parties, except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(T) Meals and lodging provided to guests and employees. If the cost cannot be ascertained, the revenue from meals and lodging furnished to guests and employees must be offset against the appropriate cost;

(U) Prescription drugs;

(V) Public relations expenses;

(W) Resident personal purchases;

(X) Return on equity;

(Y) Self-employment taxes;

(Z) Stockholder relations or stock proxy expenses;

(AA) Taxes and assessments;

(BB) Telephone, television, and radio which are located in patient accommodations and which are furnished solely for the personal comfort of patients;

(CC) Value of services (imputed or actual) rendered by non-paid workers or volunteers; and

(DD) Vending machines and related supplies.

(ii) Costs of services or supplies provided by a related entity are allowable at the actual cost incurred by the related entity. If the actual cost can not be determined, the profit percentage from the related entity's records will be used to calculate the profit percentage adjustment to the related party cost.

(b) Unsubstantiated cost.

(i) Upon written request by the Department, a nursing facility must substantiate costs or other information reported on the nursing facility's cost report. The nursing facility must provide in writing, within thirty days after the date of the request, documentation substantiating the costs or information.

(ii) Any cost which a provider cannot substantiate shall be disallowed.

(iii) Substantiation may include, but is not limited to, home office cost statement, resident census, statistical and related information, cost allocations, account analyses, invoices, stock ownership information, related parties' financial information, or subcontractor's financial information.

ATTACHMENT A

ABD Pads
Adhesive Tape
Aerosol, other types
Air Mattresses, Air P.R. Mattresses
Airway-Oral
Alcohol Plaster
Alcohol Sponges
Alternating Pressure Pads
Applicators, Cotton-tipped
Applicators, Swab-eez
Aquamatice K Pads (Water-heated Pad)
Arm slings
Asepto Syringes
Baby Powder
Bandages
Bandages, Elastic or Cohesive
Band-Aids
Basins
Bed Frame Equipment (for certain immobilized bed patients)
Bed Rails
Bedpans, all types
Beds: Manual, Electric and Clinitron
Bedside Tissues
Bibs
Blood Infusion Sets
Bottle, Specimen
Canes, all types
Cannual, Nasal
Catheter Indwelling
Catheter Plugs
Catheter Tray
Catheter (any size)
Colostomy Bags
Combs
Commodes, all types
Composite Pads

Cotton Balls
Crutches, all types
Decubitus Ulcer Pads/Dressings
Denture Cleaner/Soak
Denture Cups
Deodorants
Diapers
Disposal Under pads
Donuts
Douche Bags
Drain Tubing
Drainage Bags
Drainage Sets
Drainage Tubes
Dressing Tray
Dressing, all types
Enema Soap
Enema Supplies
Enema Unit
Equipment and Supplies for Diabetic Blood and Urine Testing
Eye Pads
Feeding Tubes
Fingernail Clipping and Cleaning
Flotation Mattress or Biowave Mattress
Flotation Pads and/or Turning Frames
Foot Cradle, all types
Gastric Feeding Unit, including bags
Gauze Sponges
Gloves, Unsterile and Sterile
Gowns, Hospital
Green Soap
Hair Brushes
Hair Care, Basic
Hand Feeding
Heat Cradle
Heating Pads
Heel Protector
Hot Pack Machine
Hydraulic Patient Lifts
Hypothermia Blanket
Ice Bags
Incontinency Care
Incontinency Pads and Pants
Influenza Vaccine
Infusion Arm Boards
Infusion Pumps, Enteral and Parenteral

Inhalation Therapy Supplies
Irrigation Bulbs
Irrigation Trays
I.V. Needles
I.V. Trays
Jelly, Lubricating
Lines, Extra
Lotion, Soap and Oil
Massages (by nursing facility personnel)
Mattresses, all types
Medical Social Services
Medicine Dropper
Medicine Cups
Nasal Catheter
Nasal Catheter, Insertion and Tube
Nasal Gastric Tubes
Nasal Tube Feeding and Feeding Bags
Nebulizer and Replacement Kit
Needles (various sizes)
Needles: Hypodermic, Scalp and Vein
Nursing Services (all) regardless of level, including the administration of oxygen and restorative nursing care
Nursing Supplies and Dressing
Ostomy Supplies: Adhesive, Appliance, Belts, Face Plates, Flanges, Gaskets, Irrigation Sets, Night Drains, Protective Dressings, Skin Barriers, Tail Closures
Overhead Trapeze Equipment
Over the counter (OTC) drugs, as designated by the Food and Drug Administration
Oxygen, Gaseous and Liquid
Oxygen Concentrators
Oxygen Delivery Systems, Portable or Stationary
Oxygen Mask
Pads
Pitcher
Plastic Bib
Pump, Aspiration and Suction
Pumps for Alternating Pressure Pads
Respiratory Equipment: Ambu Bags, Cannulas, Compressors, Humidifiers, IPPS Machines and Circuits, Mouthpieces, Nebulizers, Suction Catheters, Suction Pumps, Tubing, etc.
Restraints
Room and Board (semi-private or private if necessitated by a medical or social condition)
Sand Bags
Scalpel
Shampoo
Shaves
Shaving Cream
Shaving Razors

Sheepskin
Side Rails
Soap
Special Diets
Specimen Cups
Sponges
Steam Vaporizers
Sterile Pads
Sterile Saline for Irrigation
Sterile Water for Irrigation
Stomach Tubes
Suction Catheter
Suction Machines
Suction Tube
Surgical Dressings (including sterile sponges)
Surgical Pads
Surgical Tapes
Suture Removal Kit
Suture Trays
Syringes, all sizes
Syringes, Disposable
Tape, (for laboratory tests)
Tape, Non-allergic or Butterfly
Testing Sets and Refills (S & A)
Therapy Services, including specialized rehabilitative services as set forth in 42 C.F.R. §483.45
Toenail Clipping and Cleaning
Tongue Depressors
Toothbrushes
Toothpaste
Tracheostomy Sponges
Trapeze Bars
Tray Service
Under pads
Urinals, male and female
Urinary Drainage Tube
Urinary Tube and Bottle
Urological Solutions
Walkers, all types
Water Circulating Pads
Water Pitchers
Wheelchairs: Amputee, Geriatric, Heavy Duty, Hemi, Lightweight, One Arm Drive, Reclining, Rollabout, Semi-Reclining, Standard