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State/Territory Name: KY

State Plan Amendment (SPA) #: 22-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
233 North Michigan Ave., Suite 600
Chicago, Illinois 60601

Financial Management Group

November 10, 2022

Lisa D. Lee
275 East Main Street
Frankfort, Kentucky 40621

RE: TN 22-0008

Dear Commissioner Lee,

We have reviewed the proposed Kentucky State Plan Amendment (SPA) 22-0008, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on August 1, 2022. This SPA implements changes to the intermediate care facility for individuals with an intellectual disability, dually-licensed pediatric facility, institution for mental diseases, or a nursing facility with an all-inclusive rate unit reimbursement language in its State Plan effective August 1, 2022. The State Plan language will be changed to update certain cost principle references to follow current Medicare reimbursement principles.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), and 1903(a) of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment KY 22-0008 is approved effective August 1, 2022. We are enclosing the CMS-179 and the amended plan pages.

If you have any additional questions or need further assistance, please contact Douglas Spitler at or douglas.spitler@cms.hhs.gov

Sincerely,

Rory Howe

Todd McMillion
Director
Division of Reimbursement Review

Enclosures

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 22-0008

2. STATE: KY

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
August 1, 2022

5. FEDERAL STATUTE/REGULATION CITATION
42 CFR 447.205

6. FEDERAL BUDGET IMPACT (Amounts in WHOLE dollars)
a. FFY 2022 $ 295,268
b. FFY 2023 $ 295,286

7. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
4.19D Exhibit B Pages 1 -5
4.19D Exhibit B Pages 22-23

8. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
4.19D Exhibit B Pages 1 -5
4.19D Exhibit B Pages 22-23

9. SUBJECT OF AMENDMENT
Changes to the intermediate care facility for individuals with an intellectual disability, dually-licensed pediatric facility, institution for mental diseases, or a nursing facility with an all-inclusive rate unit reimbursement language in its State Plan effective August 1, 2022.

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
Lisa D Lee

12. TYPED NAME
Lisa Lee

13. TITLE
Commissioner

14. DATE SUBMITTED
August 22, 2022

15. RETURN TO
Lisa Lee
275 E. Main St.
Frankfort, KY 40601

FOR CMS USE ONLY

16. DATE RECEIVED
August 22, 2022

17. DATE APPROVED
November 10, 2022

PLAN APPROVED - ONE COPY ATTACHED

18. EFFECTIVE DATE OF APPROVED MATERIAL
August 1, 2022

19. SIGNATURE OF APPROVING OFFICIAL
Rory Howe

20. TYPED NAME OF APPROVING OFFICIAL
Rory Howe

21. TITLE OF APPROVING OFFICIAL
Director, FMG

22. REMARKS

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SECTION 220. INTRODUCTION TO COST-BASED REIMBURSEMENT SYSTEM

A. The Department for Medicaid Services has established a prospective reimbursement system for costs-based facilities: Cost based facilities include the following:
    1. Institutions for Mental Diseases (IMD's);
    2. Pediatric Nursing Facilities; and
    3. Intermediate Care facilities for individuals with an intellectual disability (ICF-IID).
    4. Veteran's Affairs (VA) state operated and controlled nursing facility.

The reimbursement methodology for the facilities listed is outlined here. Also included in this section are the facilities that are reimbursed by all-inclusive rates. The payment method is designed to achieve two major objectives: 1). To assure that needed facility care is available for all eligible recipients including those with higher care needs and, 2). To assure Department for Medicaid Services control and cost containment consistent with the public interest and the required level of care.

B.
    1. This cost-based system is designed to provide a reasonable return in relation to cost but also contains factors to encourage cost containment. Under this system, payment shall be made to state owned or operated, non-state but government owned or operated, and non-governmental ICF-IIDs on a prospectively determined basis for routine cost of care with no year-end adjustment required other than adjustments which result from either desk reviews or field audits.
    2. Effective with the eight month period ending June 30, 2006, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated ICF- IID. Total reimbursement to state owned or operated ICF-IID in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Cost associated with prescription drugs should be removed from the routine cost. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity.
    3. Effective with the period ending June 30, 2014, and continuing annually thereafter on a state fiscal year basis, a year-end cost settlement will be required for state owned or operated VA facilities. Total reimbursement to VA's in aggregate shall be limited to the lesser of actual costs or the amount the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 CFR 447.257 and 447.272. Effective for dates of service on or after August 1, 2014, cost associated with prescription drugs will be included as an ancillary cost. Both routine and ancillary cost shall be determined in accordance with Medicare reimbursement principles. Central Office Overhead costs for facilities that are state owned, but not state operated should be adjusted to remove costs that are determined in accordance with Medicare reimbursement principles to duplicate costs incurred by the operating entity. An interim per diem inclusive of routine, capital, and ancillary costs will be established based on the most recently submitted Medicare cost report for the July 1 rate-setting period. Costs, excluding capital, will be trended and indexed utilizing IHS Markit inflation

factors. A pro-forma cost report will be used for the initial rate-setting period if the Medicare cost report is not available. Once a desk review has been completed to review for allowable costs, and allow for Medicaid claims to process and paid through the MMIS for the period, a final cost settlement will be completed.

C. Ancillary services as defined, shall be reimbursed on a cost basis with a year-end retroactive settlement. As with routine cost, ancillary services are subject to both desk reviews and field audits that may result in retroactive adjustments.

D. The basis of the prospective payment for cost is the most recent annual cost report data (available as of May 16) trended to the beginning of the rate year and indexed to the mid-point of the prospective rate year. The routine cost is divided into two major categories: Nursing Services Cost and All Other Cost.

SECTION 230. PARTICIPATION REQUIREMENTS

PARTICIPATION REQUIREMENTS. Except for ICF-IID's and VA's, cost-based facilities participating in the Department for Medicaid program shall be required to have at least ten (10) of its Medicaid certified beds participating in the Medicare Program or twenty (20) percent of its beds if greater, but not less than ten (10) beds; for a facility with less than ten (10) beds, all beds participate in the Medicare Program.

SECTION 240. REIMBURSEMENT FOR REQUIRED SERVICES UNDER THE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR) FOR VENTILATOR UNITS, BRAIN INJURY UNITS, IMDS, AND PEDIATRIC FACILITIES.

A. Prior to admission of an individual, a nursing facility shall conduct a level I PASRR in accordance with 907 KAR 1:755, Section 4.

B. The department shall reimburse a nursing facility for services delivered to an individual if the facility complies with the requirements of 907 KAR l :755

C. Failure to comply with 907 KAR 1:755 may be grounds for termination of nursing the facility participation in the Medicaid Program.

SECTION 250. LIMITATION ON CHARGES TO RESIDENTS.

A. Except for applicable deductible and coinsurance amounts, a NF that receives reimbursement for a Medicaid resident shall not charge a resident or his representative for the cost of routine or ancillary services.

B. A NF may charge a resident or his representative for an item if the resident requests the item, the NF informs the resident in writing that there will be a charge. A NF shall not charge a resident for an item or service if Medicare or Medicaid pays for the item pursuant to 42 CFR 483.10(f)(11).

C. A NF shall not require a resident or an interested party to request any item or services as a condition of admission or continued stay. A NF shall inform the resident or an interested party requesting an item of service that a charge will be made in writing that there will be a charge and the amount of the charge.

D. A NF may charge a resident for the cost of reserving a bed if requested by resident or interested party after the fourteenth (14th) day of a temporary absence from the facility pursuant to 907 KAR 1:022.

E. Durable medical equipment (DME) and supplies shall be furnished by the NF and not be billed to the department under separate DME claim pursuant to 907 KAR 1:479.

SECTION 260. ROUTINE COST

A. Routine costs are broken down into two major categories: Nursing Service costs and All Other costs. Routine Cost includes all items and services routinely furnished to all residents.

B. NURSING SERVICES COSTS. The direct costs associated with nursing services shall be included in the nursing service cost category. These costs include:

1. Costs of equipment and supplies that are used to complement the services in the nursing services cost category;
2. Costs for education or training including the cost of lodging and meals of nursing service personnel. Educational costs are limited to either meeting the requirements of laws or rules or keeping an employee's salary, status, or position or for maintaining or updating skills needed in performing the employee's present duties;
3. The salaries, wages, and benefits of persons performing nursing services including salaries of the director of nursing and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;
4. The salaries or fees of medical directors, physicians, or other Professionals performing consulting services on medical care which are not reimbursed separately; and
5. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification or professional standards.
6. Nurse aide training costs billable to the program as an administrative cost are to be adjusted out of allowable cost.

C. ALL OTHER COSTS. Costs reported in the All OTHER COST category includes four major cost centers as reported on the annual cost report:

Other Care-Related Cost, Other Operating Costs, Indirect Ancillary Costs, and Capital Costs.

a. Other Care-Related Costs. These costs shall be reported in the other care-related services cost category:

1. Raw food costs, not including preparation;
2. Direct costs of other care-related services; such as social services and resident activities;
3. The salaries, wages, and benefits of activities' directors and aides, social workers and aides, and other care-related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid program;
4. The costs of training including the costs of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status or position, or to maintain or update skills needed in performing the employee's present duties.

b. Other Operating Costs. The costs in this category shall include the supplies, purchased services, salaries, wages and benefits for:

1. Dietary Services
2. Laundry services including the laundering of personal clothing which is the normal wearing apparel in the facility. The cost of dry cleaning personal clothing, even though it is the normal wearing apparel in the facility, is excluded as an allowable cost. Providers launder institutional gowns, robes and personal clothing which is the normal wearing apparel in the facility without charge to recipients. The recipient or responsible party may at their discretion makes other arrangements for the laundering of personal clothing.
3. Housekeeping
4. Plant Operation and Maintenance
5. General and Administrative Services

c. Capital Costs. The costs in this category shall include:

1. Depreciation on building and fixtures
2. Depreciation on equipment
3. Capital related interest expense
4. Rent

d. Indirect Ancillary Costs. Indirect ancillary costs are those costs associated with ancillary departments (including fringe benefits).

SECTION 270. ANCILLARY SERVICES

A. Ancillaries are services for which a separate charge is submitted and include:

1. Respiratory Therapy
2. Speech Therapy
3. Occupational Therapy
4. Physical Therapy
5. Oxygen Service
6. Laboratory
7. X-ray

B. Ancillary therapy services are reimbursed pursuant to 907 KAR 1:023.

C. Psychological and psychiatric services shall be billed as an ancillary service by an ICF-IID.

NOTE: Effective October 1, 1990 drugs for residents in Cost-Based Facilities shall be reimbursed through the pharmacy program.

D. Oxygen concentrator limitations. Effective October 1, 1991, the allowable cost of oxygen concentrator rentals shall be limited as follows:

1. A facility may assign a separate concentrator to any resident whom has needed oxygen during the prior or current month and for whom there is a doctor's standing order for oxygen. For the charge by an outside supplier to be considered as an allowable cost, the charge shall be based upon actual usage. A minimum charge by an outside supplier is allowable if this charge does not exceed twenty-five (25) percent of the Medicare Part B maximum. The minimum

charge is allowable if the concentrator is used less than an average of two (2) hours per day during the entire month (for example, less than 60 hours during a thirty (30) day month). The maximum allowable charge by the outside supplier shall not exceed one hundred (l00) percent of the Medicare Part B maximum. For the maximum charge to a facility to be considered as the allowable cost, the concentrator shall have been used on average for a period of at least eight (8) hours per day for the entire month (for example, 240 hours during a thirty (30) day month). In those cases where the usage exceeds that necessary for the minimum charge and is less than the usage required for the maximum charge, the reimbursable shall be computed by dividing the hours of usage by 240 and then multiplying the result of this division by the Medicare Part B maximum charge (for example, if a concentrator is used less than 220 hours during a thirty (30) day month and the maximum Part B allowable charge is $250.00; then the allowable charge is computed by dividing the 220 hours by 240 hours and then multiplying the product of this division by $250.00 to obtain the allowable charge of $229.17). Allowable oxygen costs outlined in this paragraph shall be considered to be ancillary costs.

2. A facility shall be limited to one (1) standby oxygen concentrator for each nurses' station. The Medicaid Services Program may grant waivers of this limit. This expense shall be considered as a routine nursing expense for any month in which there is no actual use of the equipment. The allowable cost for standby oxygen concentrators shall be limited to twenty-five (25) percent of the maximum allowable payment under Medicare Part B for in home use.

SECTION 280. INFLATION FACTOR

The inflation factor index shall be used in the determination of the prospective rate shall be established by the Department for Medicaid Services. The index shall be based on IHS Markit inflation factors. The index represents an average inflation rate for the year and shall have general applicability to all facilities.

The inflation factor shall be applied to nursing services costs and all other costs excluding capital.

SECTION 290. PROSPECTIVE RATE COMPUTATION

A. Prospective rates are established annually for a universal rate year, July 1 through June 30. Rate setting shall be based on the most recent cost reports available by May 16. If a desk review or audit of the most recent cost report is complete after May 16 but prior to universal rate setting for the rate year, the desk reviewed or audited data shall be utilized for rate setting. If a facility's rate is based upon a report that has not been audited or desk reviewed, the facility's rate is subject to revision after the cost report has been audited or desk reviewed.

B. Allowable routine Cost-Based Facility cost is divided into two components: Nursing Services Cost and All Other Cost.

C. Allowable cost for the Nursing Services Cost component shall be trended to the beginning of the universal rate year and indexed for the period covering the rate year based on an inflation factor obtained from the IHS Markit forecast table for Skilled Nursing Facilities.

D. Allowable cost for the All Other Cost center, with the exception of the Capital Cost sub-component shall be trended and indexed in the same manner as Nursing Services costs.

E. The total Cost-Based Facility Cost for each category, after trending and indexing, shall be divided by total Certified Cost- Based Facility days in order to compute a per diem. A minimum occupancy limit of ninety (90) percent of certified bed days available, (except for state government-owned facilities shall be seventy (70) percent of certified bed days), or actual bed days used if greater, and a maximum occupancy limit of ninety-eight (98) percent computed in the same manner, shall be used in computing the per diem.

SECTION 300. ADJUSTMENT TO PROSPECTIVE RATE

A. Upon request by participating facility, an increase in the prospective rate shall be considered if the cost increase is attributed to one (1) of the following reasons:

    1. Governmentally imposed minimum wage increases, unless the minimum wage increase was taken into account and reflected in the setting of the trending and index factor.

    2. Direct effect of newly published licensure requirements or new interpretations of existing requirements by the appropriate

governmental agency as issued in regulation or written policy material which affects all facilities within the class. The provider shall demonstrate through proper documentation that a cost increase is the result of a new policy interpretation; or

3. Other direct governmental actions that result in an unforeseen cost increase.

B. To receive a rate increase (except for Federal or State minimum wage increases), it shall be demonstrated by the facility that the amount of cost increase resulting directly from the governmental action exceeds on an annualized basis, the inflation factor allowance included in the prospective rate for the general cost area in which the increase occurs. For purposes of this determination, costs shall be classified into two (2) general categories, Nursing Service and all other.

Other Cost. Within each of these two (2) categories, costs are to be further broken down into "salaries and wages" and "other costs." Those costs directly related to salaries and fringe benefits shall be considered as "salaries and wages" when determining classifications.

C. Other unavoidable cost increases of a substantial nature, which can be attributed to a single unique causal factor, shall be evaluated with respect to allowing an interim rate change. Ordinarily budget items such as food, utilities, and interest where cost increases may occur in a generalized manner shall be excluded from this special consideration. Secondary or indirect effects of governmentally imposed cost increases shall not be considered as "other unavoidable cost increases."

D. The increase in the prospective rate shall be limited to the amount of the increase directly attributable to the governmental action to the extent that the increase on an annualized basis exceeds the inflation factor allowance included in the prospective rate for the cost center in question. In regard to minimum wage increases, the direct effect shall be defined as the time worked by total facility employees times the dollar amount of change in the minimum wage law. However, the amount allowed shall not exceed the actual salary and wage increase incurred by the facility in the month the minimum wage increase is effective. An exception to this shall be considered when there is an unusual occurrence that causes a decrease in the normal staff attendance in the months the minimum wage increase is effective.

E. The effective date of a prospective rate adjustment shall be the first day of the calendar month in which the direct governmental action occurred. To be allowable, a request for an adjustment to the prospective rate shall be received by the Department for Medicaid Services within sixty (60) days of the direct governmental action, except where the costs are to be accumulated.

F. If two (2) or more allowable reasons for a rate change occur in the same facility fiscal year, the costs may be accumulated and submitted at one (1) time. Each cost shall be documented. A rate adjustment, if allowed, shall be effective the first day of the calendar month in which the latest direct governmental action occurred if the request is made within the required sixty (60) days.

SECTION 310. RATE ADJUSTMENT FOR PROVIDER TAX

After January 1, 1994, provider tax forms shall be submitted to the Revenue Cabinet with the required supporting Revenue Cabinet schedules. Schedule J-Tax forms shall be submitted by providers by the end of the month in which corresponding filing with the Revenue Cabinet is made.

SECTION 320. OTHER OBRA NURSING HOME REFORM COSTS

Effective October 1, 1990 and thereafter, facilities shall be required to request preauthorization for costs that must be incurred to meet OBRA 87 Nursing Home Reform costs in order to be reimbursed for such costs. The preauthorization shall show the specific reform action that is involved and appropriate documentation of necessity and reasonableness of cost. Upon authorization by the Department for Medicaid Services, the cost may be incurred. A request for a payment rate adjustment may then be submitted to the Department for Medicaid Services with documentation of actual cost incurred. The allowable additional amount shall be added on to the facility's rate (effective with the date the additional cost was incurred) without regard to upper limits or the Cost Savings Incentive factor (i.e., the authorized Nursing Home Reform cost shall be passed through at 100 percent of reasonable and allowable costs) through June 30, 1991. For purposes of the July 1, 1991 rate setting, amounts associated with OBRA rate adjustments received prior to May 15, 1991 shall be folded into the applicable category of routine cost (subject to upper limits). Preauthorization shall not be required for

nursing home reform costs incurred during the period July 1, 1990, through September 30, 1990; however, the actual costs incurred shall be subject to tests of reasonableness and necessity and shall be fully documented at the time of the request for rate adjustment. Facilities may request multiple pre-authorizations and rate adjustments (add ons) as necessary for implementation of nursing home reform. Facility costs incurred prior to July 1, 1990, shall not (except for the costs previously recognized in a special manner. i.e., the universal precautions add-on and the nurse aid training add-on) be recognized as being nursing home reform costs. The special nursing home reform rate adjustments shall be requested using forms and methods specified by the Department for Medicaid Services. A nursing home rate adjustment shall be included within the cost base for the facility in the rate year following the rate year for which the adjustment was allowed. Interim rate adjustments for nursing home reforms shall not be allowed for period after June 30, 1993. For purposes of the July l, 1992 and July 1, 1993 rate setting, all amounts associated with OBRA rate adjustments for the preceding rate year shall be folded into the applicable category of routine cost. All nursing home reform rate adjustment requests shall be submitted by September 30, 1993.

SECTION 330. PAYMENT OF SPECIAL PROGRAM CLASSES

A. BRAIN INJURY UNIT

1. A nursing facility with a Medicaid certified brain injury unit providing pre-authorized specialized rehabilitation services for persons with brain injuries shall be paid at an all-inclusive (excluding drugs and physician cost which shall be reimbursed through the pharmacy and physician's programs) fixed rate which shall be set at $530 per diem for services provided in the brain injury unit.
2. A facility providing pre-authorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae shall be paid an all-inclusive (excluding drugs and physicians cost) negotiated rate. The negotiated rate shall be a minimum of the approved rate for a Medicaid certified brain injury unit or a maximum of the lesser of the average rate paid by all payers for this service or the facilities usual and customary charges.
3. In order to participate in the Medicaid program as a Brain Injury Provider, the facility shall:

   (a) Be Medicare and Medicaid certified;
   (b) Designate at least ten (10) certified beds that are physically contiguous and identifiable; and,
   (c) Be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF)

(d) Include administration and operations policies
(e) Governing authority
(t) Quality assurance and program evaluation.

B. VENTILATOR FACILITIES

A nursing facility recognized as providing distinct part ventilator dependent care shall be paid at an all-inclusive (excluding drugs which shall be reimbursed through the pharmacy program) fixed rate for services provided in the distinct part ventilator unit.
A distinct part ventilator unit shall:

1. Have a minimum of twenty (20) beds; and
2. Maintain a census of fifteen (15) patients.

The patient census shall be based upon the quarter preceding the beginning of the rate year, or the quarter preceding the quarter for which certification is requested if the facility did not qualify for participation as a distinct part ventilator care unit at the beginning of the rate year.

The fixed rate for hospital-based facilities shall be $460 per day. The fixed rate for freestanding facilities shall be $250 per day. The rates shall be increased or decreased based on the IHS Markit inflation factor for the rate year beginning July l, 1997.

C. FEDERALLY DEFINED SWING BEDS

A federally defined swing bed shall meet the requirements pursuant to 42 CFR 482.58.
A federally defined swing bed shall be reimbursed pursuant to 42 CFR 447.280, except for swing beds located in critical access hospitals, which are reimbursed pursuant to KRS 216.3 80.

SECTION 340. PAYMENT FOR ANCILLARY SERVICES

The reasonable, allowable, direct cost of ancillary services as defined provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and the Department shall analyze each request for

Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs.

A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

The reasonable, allowable, direct cost of ancillary services as defined and provided as a part of total care shall be compensated through the Department for Medicaid Services on a reimbursable cost basis as an addition to the prospective rate. Ancillary services shall be subject to a year-end audit, retroactive adjustment and final settlement.

Each provider shall request a percentage factor tailored to its own individual cost and charge ratios for ancillary services. These ratios shall be limited to one hundred (100) percent and each request shall be analyzed by Department for Medicaid Services staff to determine appropriateness of the requested percentage factor. Reimbursable ancillary costs shall be determined based on the ratio of Medicaid Program charges to total charges applied to direct departmental costs. A retroactive settlement between actual direct allowable costs and actual payment made by the Department for Medicaid Services shall be made at the end of the accounting period based on the facility's annual Cost Report. Indirect ancillary costs shall be included in routine cost and reimbursed through the prospective rate.

SECTION 350. RETROACTIVE ADJUSTMENT FOR ROUTINE SERVICES

A. A retroactive adjustment may be made for routine services in the following circumstances:

1. If incorrect payments have been made due to computational errors, i.e., mathematical errors, discovered in the cost basis or establishment of the prospective rate. Omission of cost data does not constitute a computational error.

2. If a determination is made by the Department for Medicaid Services of misrepresentation on the part of the provider.

3. If a facility is sold and the funded depreciation account is not transferred to the purchaser.

4. If the prospective rate has been set based on an unaudited cost report and the prospective rate is adjusted based on a desk review or field audit.

5. The appropriate cost settlement shall be made to adjust the unaudited prospective payment amounts to the correct audited prospective payment amounts.

6. If adjustments are necessary, any amounts owed the provider shall be paid by the Department for Medicaid Services. Any amounts owed the Department for Medicaid Services shall be paid in cash or recouped through the MMIS payment system

B. BANKRUPTCY OR INSOLVENCY OF PROVIDER. If, on the basis of reliable evidence, the Department for Medicaid Services has a reasonable cause for believing that, with respect to a provider, proceedings have been or may shortly be instituted in a State or Federal court for purposes of determining whether the facility is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the Department for Medicaid Services notwithstanding any other reimbursement principle or Department for Medicaid Services instruction regarding the timing or manner of adjustments, to a level necessary to insure that no overpayment to the provider is made. This section shall be applicable only to ancillary services.

SECTION 360. RETROACTIVE ADJUSTMENT FOR ANCILLARY SERVICES

A. Actual cost reimbursable to a provider shall not be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment shall be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the ancillary services rendered to the Department for Medicaid Services recipients during that period.

B. In order to reimburse the provider as quickly as possible, a partial retroactive adjustment may be made when the cost report is received. For this purpose, the costs shall be accepted as reported unless there are obvious errors or inconsistencies subject to later audit. When an audit is made and the final liability of the Department for Medicaid Services is determined, a final adjustment shall be made.

C. To determine the retroactive adjustment, the amount of the provider's total allowable ancillary cost apportioned to the Department for Medicaid Services for the reporting year is computed. This is the total amount of the reimbursement the provider is due to receive from the Department for Medicaid Services for covered ancillary services rendered during the reporting period. The total of the interim payments made by the Medicaid Program in the reporting year is computed. The difference between the reimbursement due and the payments made shall be the amount of retroactive adjustment.

D. ANCILLARY SERVICES. Upon receipt of the facility's cost report, the Department for Medicaid Services shall as expeditiously as possible analyze the report and commence any necessary audit of the report. Following receipt and analysis of any audit findings pertaining to the report, the Department for Medicaid Services shall furnish the facility a written notice of amount of Medicaid reimbursement. The notice shall (1) explain the Department for Medicaid Service's determination of total Medicaid reimbursement due the facility for the reporting period covered by the cost report or amended cost report; (2) relate this determination to the facility's claimed total reimbursable costs for this period; and (3) explain the amount(s) and the reason(s) for the determination through appropriate reference to the Department for Medicaid Services policy and procedures and the principles of reimbursement. This determination may differ from the facility's claim.

The Department for Medicaid Services' determination as contained in a notice of amount of Medicaid reimbursement shall constitute the basis for making the retroactive adjustment to any Medicaid payments for ancillary services made to the facility during the period to which the determination applies, including the suspending of further payments to the facility in order to recover, or to aid in the recovery of, any overpayment determined to have been made to the facility.

E. ROUTINE SERVICES. When a retroactive adjustment is made to the routine rate, the Fiscal Agent shall adjust all routine payments made based on the rate that was adjusted.

SECTION 370. PAYMENTS FOR SERVICES TO MEDICARE/MEDICAID RESIDENTS

A. Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to exhaust any applicable benefits under Title XVIII (Part A and Part B) prior to coverage under the Medicaid Program.

B. APPLICATION. Services received by a resident that are reimbursable by Medicare shall be billed first to the Medicare Program. Any appropriate co-insurance or deductible payment due from the Medicaid Program shall be paid outside the Cost-based facility Cost-Related Payment System in a manner prescribed by the Department for Medicaid Services. Coinsurance and deductible payments shall be based on rates set by the Medicaid Program. A day of service covered in this manner shall be considered a Medicare resident day and shall not be included as a Medicaid resident day in the facility cost report.

SECTION 380. RETURN ON EQUITY OF PROPRIETARY PROVIDERS

An allowance for a return on equity capital invested and used in the provision of resident care shall not be allowed.

SECTION 390. DESK REVIEW AND FIELD AUDIT FUNCTION

After the facility has submitted the annual cost report, the Division of Fiscal Management shall perform an initial desk review of the report. During the desk review process, Medicaid staff or the Department's contractor shall subject the submitted Cost Report to various tests for clerical accuracy and reasonableness. If the Medicaid Program detects clerical error, the Department for Medicaid Services shall return the submitted Cost Report to the providers for correction. If Medicaid staff suspect possible errors rather than simple clerical errors, the Medicaid staff shall require the provider to submit supporting documentation to clarify any areas bought into question during the desk review. The desk review shall not be deemed to be completed until all clerical errors have been rectified and all questions asked of the provider during the desk review process have been answered fully.

Additionally, results of this desk review shall be used to determine whether a field audit, if any, is to be performed. The desk review and field audits shall be conducted for purposes of verifying prior year cost to be used in setting prospective rates which have been set based on unaudited data. Ancillary service cost shall be subject to the same

desk review and field audit procedure to settle prior year costs. The field audit procedures shall include an audit of Resident Fund Accounts to insure the Medicaid Program that the providers are in compliance with appropriate federal and state regulations.

SECTION 400. REIMBURSEMENT REVIEW AND APPEAL

A NF may appeal department decisions as to the application of this regulation as it impacts the NF's cost-based reimbursement rate in accordance with 907 KAR 1:671, Section 10.

SECTION 410. INTRODUCTION TO PROVIDER COST THAT ARE REIMBURSABLE

A. The material in this Section deals with provider costs that are reimbursable by the Department for Medicaid Services. In general, these costs are reimbursed on the basis of a provider's actual costs, providing these costs are reasonable and related to resident care. These costs are termed allowable costs. That portion of a provider's total allowable costs allocable to services provided to Medicaid Program recipients shall be reimbursable under the Medicaid Program.

B. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, if the facility's operating costs include amount not related to resident care, specifically not reimbursable under the Medicaid Program or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts shall not be allowable.

C. If a provider presents a question concerning the treatment of cost not specifically covered, or desires clarification of information, the provider may make a request for determination. The request shall include all pertinent data in order to receive a binding response. Upon receipt of the request, the Department for Medicaid Services shall issue a binding response within sixty (60) days.

SECTION 420. ADEQUATE COST DATA

A. To receive reimbursement for services provided Medicaid Program recipients, providers shall maintain financial records and statistical data sufficient to allow proper determination of costs payable under the Medicaid Program. This cost data shall be of sufficient detail to allow verification by qualified auditors using General Accounting Office and American Institute of Certified Public Accountants guidelines. The cost data shall be based on Generally Accepted Accounting Principles.

B. Use of the accrual basis of accounting is required. Governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

   Under the accrual basis of accounting, revenue is reported in the period in which it is earned regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid. To allow comparability, financial and statistical records shall be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

C. Providers, when requested, shall furnish the Department for Medicaid Services copies of resident service charge schedules and changes as they are put into effect. The Department for Medicaid Services shall evaluate charge schedules to determine the extent to which they may be used for determining Medicaid payment.

D. Where the provider has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for service costing or valued at $10,000 or more over a twelve (12)-month period, the contract shall contain a clause giving the Cabinet for Health Services access to the subcontractor's books. Access shall also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until four (4) years have expired after the services have been furnished.

E. If the Department for Medicaid Services determines that a provider does not maintain or no longer maintains adequate records for the determination of reasonable cost, payments to the provider shall be suspended until the Department for Medicaid Services is assured that adequate records are maintained.

F. A newly participating provider of services shall, upon request, make available to the Department for Medicaid Services for examination its fiscal and other records for the purpose of determining the provider's ongoing record keeping capability.

G. Records shall be retained by the facility for three (3) years from the date the settled-without-audit or the audited cost report is received from the Department for Medicaid Services.

The financial records and statistical data that shall be kept shall include the following:

1. Records and documents relating to facility ownership, organization, and operation;
2. All invoices and purchase orders;
3. All billing forms or charge slips;
4. All agreements pertaining to asset acquisition, lease, sale or other action;
5. Documents pertaining to franchise or management arrangements including costs of parent or "home office" operations;
6. Resident service charge schedules;
7. Contracts pertaining to the purchase of goods or services;
8. All accounting books or original entry kept in sufficient detail to show source and reason for all expenditures and payments;
9. All other accounting books;
10. Federal and State income tax returns;
11. Federal withholding and State Unemployment returns; and,
12. All financial statements regardless whether prepared by the facility or by an outside firm;
13. Any documentation required by the Department shall be made available for examination; and,
14. All of these records shall be made available for examination at the facility, or at some other location within the Commonwealth, when requested by the Cabinet for Health Services. Reasonable time

shall be given to out- of-state home offices to make the records available within the Commonwealth.

SECTION 430. APPORTIONMENT OF ALLOWABLE COST

A. Consistent with prevailing practices where third party organizations pay for health care on a cost basis, reimbursement under the Medicaid Program involves a determination of (1) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payers.

   Cost apportionment is the process of recasting the data derived from the accounts ordinarily kept by a provider to identify costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and pro-ration of indirect costs.

B. The objective of this apportionment is to ensure, to the extent reasonably possible, that the Medicaid Program's share of a provider's total allowable costs is equal to the Medicaid Program's share of the provider's total services, subject to Medicaid Program limitations on payments so as not to pay for inefficiencies and to provide a financial incentive for providers to achieve cost efficiencies.

SECTION 440. COST REPORTING

A. The Medicaid Program requires each Cost-Based Facility to submit an annual report of its operations. The report shall be filed for the fiscal year used by the provider unless otherwise approved by the Medicaid Program.

B. Amended cost reports (to revise cost report information that has been previously submitted by a provider) may be permitted or required as determined by the Medicaid Program.

C. The cost report shall be due within sixty (60) days after the provider's fiscal year ends for non-VA facilities. The VA cost report shall be due within 5 months after the provider's fiscal year end, unless an extension has been approved by the Department.

D. Providers may request in writing a thirty (30) day extension. The request shall explain in detail why the extension is necessary. There shall be no automatic extension of time for the filing of the cost report. After the extension period has elapsed, the Medicaid Program shall suspend all payments to the provider until an acceptable cost report is received.

E. Newly participating providers not having a cost report on file containing twelve (12) months of actual data in the fiscal year shall submit a partial year cost report. Upon entry into the Medicaid Program, the provider shall inform the Department of Medicaid Services of the period ending date for the initial cost reporting period.

F. A provider that voluntarily or involuntarily ceases to participate in the Medicaid Program or experiences a change of ownership shall file a cost report for that period under the Medicaid Program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement. The report shall be due within forty-five (45) days of the effective date of termination of the provider agreement. If a new owner's fiscal year end is less than six (6) months from the date of the change of ownership, Schedules A. D-5 and E as well as the ancillary portion of Schedule F shall be required to be filed at the end of the fiscal year. The rate paid to the new owner shall be the old owner's rate and shall remain in effect until a rate is again determined for a new universal rate year.

SECTION 450. BASIS OF ASSETS

A. PRINCIPLE. Unless otherwise stated, the basis of an asset shall be the purchase price of that asset paid by the current owner.

B. REVALUATION UPON CHANGES IN OWNERSHIP. If there is a change in ownership, the Medicaid Program shall treat the gain or loss on the sale of an asset in accordance with one (1) of the following methods (dependent on the date of the transaction) for purposes of determining a purchaser's allowable basis in relation to depreciation and interest costs.

1. For changes of ownership occurring prior to July 18, 1984, or if an enforceable agreement for a change of ownership was entered into prior to July 18, 1984, the following methodology applies:

a. The actual gain on the sale of the facility shall be determined. Gain shall be defined as any amount in excess of the seller's depreciated basis at the time of the sale as computed under the Medicaid Program policies. The value of Goodwill included in the purchase price shall not be

considered part of the gain for purposes of determining the purchaser's cost basis.

b. Two-thirds (2/3) of one (1) percent of the gain for each month of ownership since the date of acquisition of the facility by the seller shall be added to the seller's appreciated basis to determine the purchaser's allowable basis. This method recognizes a graduated proportion of the gain on the sale of a facility that shall be added to the seller's depreciated basis for computation of the purchaser's allowable basis. This allows full consideration of the gain by the end of twelve and one-half (12 1/2) years.

2. For changes of ownership occurring on or after July 18, 1984, the allowable basis for depreciation for the purchaser shall be the lesser of: 1) the allowable basis of the seller, at the time of the purchase by the seller, less any depreciation allowed to the seller in prior periods; plus the cost of any improvement made by seller, less the depreciation allowed to the seller on those improvements, at the time of closing, or 2) the actual purchase price.

C. If a provider wishes to change its fiscal year, approval shall be secured in advance from the Department for Medicaid Services prior to the start of the fourth quarter of the original reporting period. If a provider has changed its fiscal year and does not have twelve (12) months in its most recent fiscal year, the provider shall file a cost report for its new fiscal year and include twelve (12) months of data, i.e., the provider should use all months included in their new fiscal year plus additional months from the prior fiscal year to construct a twelve (12) month report.

SECTION 460. DEPRECIATION EXPENSE

A. PRINCIPLE. An appropriate allowance for depreciation expense on buildings and equipment shall be an allowable expense. The depreciation shall be:
   1. Identifiable and in the facility's accounting records
   2. Based on the allowable basis;
   3. Prorated over the useful life of the asset; and,
   4. Goodwill and other intangible assets shall not be depreciated

B. METHOD OF DEPRECIATION. Assets shall be depreciated using the straight-line method, unless Medicare has authorized another method for the facility; in which case, the facility may elect to utilize the method authorized for Medicare purposes.

C. USEFUL LIVES. In selecting a proper useful life, the 1988 Edition (or more currently available version) of the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" shall be used with respect to assets acquired in 1989 or later years. For assets acquired from 1983 through 1988, the 1983 Edition of the AHA's guidelines shall be used. For assets acquired before 1982, the 1973 Edition of the AHA's "Chart of Accounts for Hospitals" shall be used, or for assets acquired before 1981, guidelines published by the Internal Revenue Service, with the exception of those offered by the Asset Depreciation Range System, shall be used.

SECTION 470. INTEREST EXPENSE

A. PRINCIPAL. Unless otherwise stated, interest expense shall be an allowable cost pursuant to 42 CFR 413.153.

B. DEF1N1TIONS.

1. "Interest" means interest is the cost incurred for the use of borrowed funds.
2. "Necessary" means necessary requires that interest:
    a. Be incurred on a loan made to satisfy a financial need of the provider that is related to resident care. Loans that result in excess funds or investments shall not be considered necessary.
    b. Be incurred on a loan made for the following purposes:
    c. Represent interest on a long-term debt existing at the time the provider enters the Medicaid Program plus interest on any new long-term debt, the proceeds of which are used to purchase fixed assets relating to the provision of the appropriate level of care not to exceed the allowable basis of the assets. If the debt is subject to variable interest rates found in "balloon"

type financing, renegotiated interest rates subject to tests of reasonableness should be allowable. The form of indebtedness may include mortgages, bonds, notes, and debentures when the principal is to be repaid over a period in excess of one year.

1) Other interest for working capital and operating needs that directly relate to providing resident care is an allowable cost. Working capital interest shall be limited to the interest expense that would have been incurred on two months of Medicaid Receivables. The amount of which this limitation is to be based is computed for cost reporting purposes by determining the monthly average Medicaid payments (both routine and ancillary) for the Cost Reporting period and multiplying the amount by two (2). Once the allowable amount of borrowing has been determined, it is multiplied by the provider's average working capital borrowing rate in order to determine the maximum allowable working capital interest. It should be emphasized that the two-month limit is a maximum. Working capital interest shall not be allowable simply because it does not exceed the two month limitation. Working capital interest that meets the two-month test shall meet all other tests of necessary and proper in order for it to be considered allowable.

2) Be reduced by investment income except where such income is from gifts and grants, whether restricted or unrestricted, and which are held separate and not commingled with other funds, or have been separated, if necessary. When investment income is derived from combined or pooled funds, only that portion of investment income

resulting from the facility's assets after segregation shall be considered in the reduction of interest cost. Income from funded depreciation, a provider's qualified pension fund, or a formal deferred compensation plan shall not be used to reduce interest expense so long as these funds are used only for those purposes for which they were created.

3. Proper Interest Rate

   a. Be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market existing at the time the loan was made.
   b. Be paid to a lender not related through control or ownership, or personal relationship to the borrowing organization. However, interest is allowable if paid on loans that meet one of the related party exemptions.

C. BORROWER-LENDER RELATIONSHIP.

1. To be allowable, interest expense shall be incurred on indebtedness established with lenders or lending organizations not related through control, ownership or personal relationship to the borrower. Presence of any of these factors could affect the "bargaining" process that usually accompanies the making of a loan, and could thus be suggestive of an agreement on higher rates of interest or of unnecessary loans. Loans shall be made under terms and conditions that a prudent borrower would make in arms- length transactions with lending institutions. Thus, interest paid by the facility to partners, stockholder, or related organizations of the facility shall not he allowable.

2. Exceptions to the general rule regarding interest on loans from controlled sources of funds are made in the following circumstances. Interest on loans to those facilities classified as Intermediate Care Facilities prior to October 1, 1990, by partners, stockholders, or related organizations made prior to July I, 1985 shall be allowable as cost, as determined under these principles, provided that the terms and conditions of payment of such loans

have been maintained in effect without subsequent modification subsequent to July 1, 1975.

3. Facilities prior to October 1, 1990, the same policy applies for this type loan made prior to and maintained without modification subsequent to December I, 1979. If the general fund of a provider "borrows" from a donor-restricted fund and pays interest to the restricted fund, this interest expense is an allowable cost. The same treatment shall be accorded interest paid by the general fund on money "borrowed" from the funded depreciation account of the provider or from the provider's qualified pension fund. In addition, if a facility operated by members of a religious order borrows from the order, interest paid to the order shall be an allowable cost.

4. If funded depreciation is used for purposes other than improvements, replacement, or expansion of facilities or equipment related to resident care, allowable interest expense shall be reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment shall be accorded deposits in the provider's qualified pension fund where such deposits are used for other than the purposes for which the fund was established. If a facility is sold and the funded depreciation account is not transferred to the purchaser, the earnings of the funded depreciation account shall be treated as an investment income. Any investment income that had been earned by the funded depreciation account and had not been utilized to reduce interest expense, shall be considered an overpayment by the Medicaid Program and a retroactive cost settlement shall be computed at the time of the sale. If the funded depreciation account is transferred to the purchaser and the purchaser eliminates the account, any investment income earned in prior years by the account shall be offset against interest expense of the purchaser.

D. INTEREST NOT REASONABLY RELATED TO RESIDENT CARE

Interest expense is not reasonably related to resident care if:

1. It is paid on borrowings in excess of the allowable basis of the asset.
2. It is made to defer principle payments.
3. It is used to purchase goodwill or other intangible asset.
4. It is in the form of penalty payments.

E. INTEREST EXPENSE ON PURCHASES OF FACILITIES ON OR AFTER JULY 18, 1984. For facilities purchased on or after July 18, 1984, but before October I, 1985, the amount of interest expense allowed purchaser shall be limited to the amount that was allowable to the seller at the time of the sale. For facilities purchased on or after October 1, 1985, the amount of interest expense allowed to the purchaser shall be limited to the interest on the allowable basis of the asset reduced by the amount necessary (if applicable) to ensure that the increase in depreciation and interest paid to facilities purchased on or after October l, 1985 does not exceed $3,000,000 annually. Any reduction of allowable interest based on the $3,000,000 limit shall be prorated proportionately among the affected facilities (i.e., the percentage reduction shall be applied equally.)

SECTION 480. FACILITY LEASE OR RENT ARRANGEMENTS

A. For cost-based nursing facilities previously classified as Intermediate Care Facilities, the allowable cost of all lease or rent arrangements occurring after 4/20/76 shall be limited to the owner's allowable historical costs of ownership. The effective date of this limitation for nursing facilities previously classified as Skilled Nursing Facilities is 12/1/79. Historical costs of ownership can include the owner's interest expense, depreciation expense, and other costs such as taxes, insurance, maintenance, etc. In the event of the sale or leaseback arrangement, only the original owner's allowable basis shall be recognized. The owner's allowable historical cost shall be subject to the basis limitations as applied to property owned by providers. Additionally, allowable depreciation and interest shall not exceed that which would have been allowed had the provider owned the assets. In order to have the allowable cost determined and approved, all data pertaining to the lease or rent arrangement, including the name of previous owners, shall be submitted by the provider. In regard to lease or rent arrangements occurring prior to 4/20/76 for basic Intermediate Care and 12/1/79 for Skilled Nursing, the Medicaid Program shall determine the allowable Costs of such arrangements based on the general reasonableness of costs.

B. Lease or Rent arrangements for land only shall be considered an allowable cost if the lease agreement does not contain an option to purchase at less than market value. If the lease amount is a set amount each year, the lease amount should be reclassified to the Depreciation Expense cost center. If

the lease amount varies from one (l) year to the next, the lease amount shall be reclassified to the Operation and Maintenance of Plant cost center.

SECTION 490. CAPITAL LEASES

Leases determined to be Capital Leases under Generally Accepted Accounting Principles (GAAP) shall be accounted for under the provisions of GAAP.
However, all basis limitations applicable to the depreciation and interest expense of purchased assets shall apply to Capital Leases.

SECTION 500. AMORTIZATION OF ORGAN1ZATlON AND START-UP COSTS

Organization and start-up costs as defined in Health Insurance Manual 15 shall be amortized in accordance with the provisions of Health Insurance Manual 15.

SECTION 510. ACCELERATED DEPRECIATION TO ENCOURAGE REFINANCING

A. To encourage facilities to refinance loans for long term debt in existence on December 1, 1992 at lower interest rates and for shorter duration that their current financing, the Kentucky Medicaid Program shall allow an increase in depreciation expense equal to the increased principal payments (principal payments on the allowable portion of the loan under the new financing minus the principal payments under the old financing on the allowable portion of the loan). However, this increase in allowable depreciation expense shall not exceed the reduction in allowable interest expense that results from the refinancing. Interest savings for any period shall be computed as follows: allowable interest expense which would have been incurred under the previous loan, plus allowable amortization of financing costs which would have been incurred under the previous financing arrangement, minus allowable interest expense under the new financing arrangement, minus allowable amortization of loan costs under the new loan (including any unamortized loan expense from the previous loan.) Total depreciation allowed (including the additional depreciation) shall reduce the allowable depreciable basis of the building. Total depreciation expense allowed over the lives of the assets that make up the facility shall not exceed the allowable undepreciated basis of the building. The additional depreciation allowed by the

provision shall first be applied against the allowable basis of the longest lived asset which has any remaining allowable undepreciated basis. The remaining allowable undepreciated basis of the facility at the end of the refinanced loan, shall be depreciated over the remaining useful lives of the assets utilizing straight line depreciation. If subsequent to the refinancing and claiming of accelerated depreciation, the facility is sold (either the operating entity holding the nursing facility licensure or the building on which the accelerated depreciation is claimed) or the facility voluntarily discontinues participation in the Medicaid Program, the following recapture provisions shall be applied:

1. The owner who claimed the accelerated depreciation shall pay the Medicaid Program an amount equal to the difference in depreciation claimed for the certified nursing facility with and without the accelerated depreciation times the average Medicaid percentage of total occupancy in the certified nursing facility.

2. If the facility remains in the Medicaid Program, the allowable depreciable basis for the new owner shall be the allowable depreciable basis had the prior owner never utilized accelerated depreciation for Medicaid reimbursement.

SECTION 520. BAD DEBTS, CHARITY, AND COURTESY ALLOWANCES

Applied in accordance with 42 CFR 413.89.

SECTION 530. COST OF EDUCATIONAL ACTIVITIES

A. PRINCIPLE. An appropriate part of the net cost of approved educational activities shall be an allowable cost.

B. DEFINITIONS.

1. "Approved Educational Activity" means an educational activity formally organized or planned program of study usually engaged in by providers in order to enhance the quality of resident care in a facility. These activities shall be licensed where required by state law. If license is not required, the facility shall receive approval from the recognized national professional organization for the particular activity.

2. "Net Cost" means the cost of approved educational activities (including stipends of trainees, compensation of teachers, and other costs), less any reimbursements from grants, tuition, and specific donations.

3. "Appropriate Part" means the net cost of the activity apportioned in accordance with the methods set forth in these principles.

C. ORIENTATION AND ON-THE-JOB TRAINING. The costs of "orientation" and "on the job training" shall not be within the scope of this principle but shall be recognized as normal operating costs.

SECTION 540. RESEARCH COSTS

Applied in accordance with 42 CFR 413.90.

SECTION 550. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

A. PRINCIPLE. For cost report periods finalized on or after August 1, 2022, grants, gifts, and income from endowments, whether or not the donor restricts the use for a specific purpose, are not deducted from a provider's operating costs in computing reimbursable costs, in accordance with Medicare cost reimbursement guidelines.

B. DEFINITIONS.

1. "Unrestricted Grants, Gifts and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, given to a facility without restriction by the donor as to their use.

2. "Designated or Restricted Grants, Gifts, and Income from Endowments" means grants, gifts, and income from endowments, funds, cash or otherwise, which shall be used only for the specific purpose designated by the donor. This does not refer to unrestricted grants, gifts, or income from endowments that have been restricted for a specific purpose by the facility.

SECTION 560. VALUE OF SERVICES OF NONPAID WORKERS

Applied in accordance with 42 CFR 413.94.

SECTION 570. PURCHASE DISCOUNTS AND ALLOWANCES AND REFUNDS OF EXPENSES

Applied in accordance with 42 CFR 413.98.

SECTION 580. COST TO RELATED ORGANIZATIONS

Applied in accordance with 42 CFR 413.17.

SECTION 590. DETERMINATION OF ALLOWABLE COST OF SERVICES, SUPPLIES, AND EQUIPMENT

A. PRINCIPLE. Reimbursement to providers for services, supplies and equipment shall be based on reasonable allowable cost as defined in this section.

B. DETERMINING ALLOWABLE COST. The allowable cost of services, supplies and equipment shall exceed the lowest of:

1. The acquisition of cost the provider;
2. The provider's usual and customary charge to the public;
3. The prevailing charge in the locality as determined by Medicare or the Department for Medicaid Services as applicable; or
4. If the item or service is identified in the Federal Register as one that does not vary significantly in quality from one supplier to another, the lowest charge level as defined in 42 CFR 405.511.

SECTION 600. COST RELATED TO RESIDENT CARE

A. PRINCIPLE. All payments to facilities shall be based on the reasonable cost of covered services and related to the care of recipients. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, payments to facilities shall be based on the lesser of the reasonable cost of covered services furnished to Medicaid Program recipients or the customary charges to the general public for such services.

Reasonable cost of any services shall be determined in accordance with the principles of reimbursement establishing the method or methods to be used, and the items to be included. These principles take into account both direct and indirect costs of facilities. The objective is that under the

methods of determining cost, the costs with respect to individuals covered by the Medicaid Program shall not be borne by individuals not so covered, and the costs with respect to individuals not so covered shall not be borne by the Medicaid Program.

SECTION 610. REIMBURSEMENT FOR SERVICES OF PHYSICIANS

A. PRINCIPLE. If the physician bills the Medicaid Program for services provided to the resident directly, such amount is to be approved and paid in accordance with the established practices relating to the physician element of the Medicaid Program. If the physician does not bill the Medicaid Program for services provided to the resident, costs to the facility are recognized as indicated in paragraph (C) of this section.

B. REASONABLE COST. For the purposes of determining reasonable costs of services performed by physicians employed full time or regular part- time, reasonable cost of the services shall not exceed what a prudent and cost-conscious buyer would pay for comparable services by comparable providers.

C. APPLICATION. If the physician is compensated by the facility for medical consultations, etc., on a part time basis, the amounts paid to the physician, if reasonable, shall be recognized by the Medicaid Program as an allowable cost. Physician services by a part-time facility employee for medically necessary direct resident services shall be paid the physician directly through the physician's element of the Medicaid Program. If the physician is a full-time employee of a nursing facility all reasonable costs including direct resident services, shall be recognized as routine facility costs and shall not be billed to the Medicaid Program directly by the physician.

SECTION 620. MOTOR VEHICLES

A. Costs associated with motor vehicles that are not owned by the facility, including motor vehicles that are registered or owned by the facility but used primarily by the owner, or family members thereof shall be excluded as allowable costs.

B. In 1986 Kentucky state law established allowable motor vehicle costs to be $15,000 per vehicle, up to three (3) vehicles, if the vehicle is used for facility business. The allowable amount is adjusted annually for inflation according to the increase in the consumer price index for the most recent twelve-month period. Medically equipped motor vehicles shall be exempt from the limit. The Department may approve costs exceeding the limit on a facility by facility basis upon demonstration by the facility that additional costs are necessary for the operation of the facility.

SECTION 630. COMPENSATION OF OWNERS

Applied in accordance with 42 CFR 413.102.

SECTION 640. OTHER COSTS

A. The cost of maintaining a chapel within the facility shall be allowable providing the cost is reasonable.

B. The cost associated with facility license fees shall be allowed if proper documentation proves that the payment is a fee and not a tax.

C. The costs associated with political contributions and legal fees for unsuccessful lawsuits filed by the provider shall be excluded from allowable cost. Legal fees relating to lawsuits against the Cabinet for Health and Family Services shall only be included as a reimbursable cost in the period in which the suit is settled after a final decision has been made that the lawsuit is successful or when otherwise agreed to by the parties involved or ordered by the court.

D. The costs for travel and associated expenses outside the Commonwealth of Kentucky for purposes of conventions, meetings, assemblies, conferences or any related activities that shall not be allowable costs. However, costs (excluding transportation costs) for training or educational purposes outside the Commonwealth of Kentucky (except for owners or administrators) shall be allowable costs. Meetings per se shall not be considered educational; however, if educational or training components are included, the cost, exclusive of transportation shall be allowable. However, travel and associated expenses outside the Commonwealth of Kentucky shall not be allowable for owners and administrators for any reason.

E. The cost of corporate income tax preparation shall be an allowable cost.

F. Stockholder maintenance or servicing costs, such as preparation of an annual report, fees for filings required by the SEC etc., shall be allowable costs.

G. The cost of the Board of Directors' fees shall be allowable, but shall be limited to five (5) meetings annually for single facility organizations and twelve (12) meetings annually for multiple facility organizations and shall meet a test of reasonableness. Other cost associated with Board of Directors' meetings in excess of the above limitations on the number of meetings shall also be considered to be unallowable costs.

H. Profits or revenues of the parent organization which are from sources not related to the provision of Cost Based Facility care shall not be considered as reductions in the cost to the Medicaid Program if the investment funds that generated these profits or revenues were not co-mingled with investment funds of the facility, or have been un-comingled, if necessary, and the source of the funds can be identified according to generally accepted accounting procedures.

I. Employee leave time, if vested, shall be generally an allowable cost. For leave pay to be vested there shall be no contingencies on the employee's right to demand cash payment for unused leave upon termination of employment. Facilities continue to have the option of accounting for leave on an accrual or cash basis. If a facility wishes to switch its accounting method to the accrual accounting basis, the accumulated carryover from the prior year(s) may be expensed as utilized, in accordance with the facility's personnel rules concerning the taking of leave. Concurrent with the expensing of the carryover, current vacation earned shall be accrued

J. Costs resulting from anti-union activity shall be disallowed. Costs associated with union activity, unless prohibited by the National Labor Relations Act or unless the costs are unreasonable or unnecessary, shall be allowed.

K. In accordance with KRS 216.560(4), payment of penalties shall not be made from monies used for direct resident care nor shall the payment of penalties be a reimbursable cost under Medicaid.

L. The costs associated with private club memberships shall be excluded from allowable costs.

SECTION 650. ANCILLARY COST

A. Reasonable cost of ancillary services provided as a part of total care are reimbursable, but may be subject to maximum allowable cost limits under Federal regulations.

Ancillary services include:

Physical therapy
Occupational Therapy
Speech Therapy
Laboratory procedures
X-Ray
Oxygen
Respiratory therapy (excluding the routine administration of oxygen)

Appropriate time and cost records of therapy services shall be maintained. All contracted services shall be documented by invoices which clearly delineate charges for the service(s) provided to include the resident who received the service, the date the service was provided, the length of time the service required, and the person providing the service. Supplies and equipment shall be itemized separately from treatment on these invoices.

B. DIRECT ANCILLARY COSTS. The direct ancillary costs of Physical, Occupational, Speech and Respiratory Therapy shall include only costs of equipment used exclusively for the specific therapy services, and the salary costs, excluding fringe benefits, of qualified therapy personnel who perform the service, or persons who perform the service under the on-site supervision of qualified therapy personnel.

Personnel qualified for respiratory therapy direct ancillary cost purposes shall be those qualified individuals either licensed by the Kentucky Board of Respiratory Care or the Kentucky Board of Nursing. This definition applies without regard to whether they are facility or hospital-based, or are an independent contractor.

C. The cost of providing general nursing care, including the routine administration of oxygen, routine suctioning or for standby services shall not be direct ancillary costs. Acquisition, after December 1, 1979, of therapy equipment with a total value of $1,000 for each asset shall have prior approval by the Department for Medicaid Services in order to be recognized as an allowable cost by the Medicaid Program.

SECTION 660. UNALLOWABLE COSTS

A. COSTS EXCLUDED FROM ALLOWABLE COSTS
   1. Ambulance service

2. Private duty nursing
3. Luxury items or services
4. Dental services
5. Noncompetitive agreement costs
6. Cost of meals for other than residents and provider personnel
7. Dry cleaning of the resident's personal clothing
8. Drug costs
9. An allowance for a return on equity is not reimbursable.

SECTION 670. SCHEDULE OF IMPLEMENTATION

The reimbursement system in effect as of July 1, 1990 shall remain in effect for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID) through June 30, 1991 with the following exceptions:

A. Effective October 1, 1990, drugs shall no longer be treated as an ancillary for ICF- IID facilities.

B. Drugs shall be billed through the Pharmacy Program. The pharmacist shall bill Medicaid directly and the facility shall no longer act as a conduit for drug billings.

C. Those medical supplies previously billed as drugs that cannot be billed through the Pharmacy Program shall be treated as routine-cost for services provided on or after October 1, 1990.

SECTION 680. INTRODUCTION TO THE COST-BASED PAYMENT SYSTEM

This payment system is designed for ICF-IID facilities that are providing services to Medicaid recipients and are to be reimbursed by the Department for Medicaid Services. Effective for costs used in rate setting as of July l, 1991 except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services. Cost-Based Facilities Reimbursement shall be applicable to ICF-IID facilities.

The intent of this reimbursement system is to recognize the reasonable costs associated with the services and level of care provided by ICF-IID facilities.

SECTION 690. OCCUPANCY LIMITATION EXCEPTIONS

If a facility is mandated by a court to reduce the number of beds, the occupancy limitations shall not be applied while alternative placement of residents is being attempted in order to comply with the court ruling. During the transition period, defined by the court the facility shall be allowed a rate adjustment, not more often than monthly, which utilizes the actual facility occupancy.

SECTION 700. DEFINITION OF ROUTINE AND ANCILLARY SERVICES

The definitions of routine and ancillary services as previously stated shall be applicable to the ICF-IID facilities. Psychological and psychiatric services shall be billed as ancillary services by an ICF-IID.

SECTION 705. MEDICARE UPPER PAYMENT LIMIT (UPL) - ROUTINE COSTS

The estimate of the amount that would be paid under Medicare payment principles (The Medicare UPL") is based on the following methodology. A base year shall be established utilizing cost and utilization data from all state owned or operated ICF-IID facilities most recent desk audited cost reports for state fiscal year (SFY) 2005. Excluding capital and ancillary costs from these cost reports, a weighted mean cost per day will be computed by dividing the total aggregate routine costs for state owned or operated ICF-IIDs by the total aggregate cost report days for state owned or operated ICF-IIDs. The weighted mean cost per day will be multiplied by 112% to determine an adjusted weighted mean cost per day. The adjusted weighted mean cost per day will be trended forward by applying a rate of change equal to the IHS Markit Skilled Nursing Facility Market basket without capital for the rate year. This process will determine the estimated Medicare reimbursement cost per day for the rate year. To determine the Medicare UPL for SFY 2006, take the trended Medicare cost per day multiplied by the actual Medicaid patient days for the current fiscal year (SFY 2005). The current fiscal year patient days will be determined using actual Medicaid patient days from the previous SFY. Medicare UPL calculations for future SFYs will be determined by trending the prior year estimated Medicare reimbursement cost per day forward by the IHS Markit Skilled Nursing Facility Market basket without capital for the rate year and multiplying this by actual Medicaid patient days from the previous SFY. This Medicare UPL process will remain in effect for each SFY until the designation of a new base year. A new base year shall be established no more frequently than once every three years based on the most recent desk audited cost report data available.

The Medicare UPL for non-state but government owned or operated and nongovernmental ICF-IIDs shall be calculated using the same method as the state owned or operated ICF-IIDs; however, the aggregate cost and utilization data will come from their own most recent desk audited cost' reports.

For each rate year, the estimated Medicare UPL calculated as described above shall only increase to take into account any cost that ICF-IID facilities are required to incur to comply with the conditions described in Att. 4.19-D, page 3 or Section 300 of Att.4.19-D, Exhibit B, that were not in effect during the Medicare UPL base year. The increase will be equal to the average per diem cost of complying with such requirements times the total number of Medicaid patient days in the Medicare UPL current year as defined above. The year-end cost settlement will incorporate the additional payments.

SECTION 706. MEDICARE UPPER PAYMENT LIMIT (UPL) - ANCILLARY AND CAPITAL COSTS

Ancillary and capital costs will be limited to actual allowable cost based on Medicare Principles of Reimbursement. Allowable cost will be determined based on the provider's annual cost reports that have been audited and cost settled by Kentucky's Department for Medicaid Services. The total allowable ancillary and capital costs will be added to the routine cost determined in Section 705. This total cost' will be the final annual Medicare UPL.

SECTION 710. LEASE OR RENT ARRANGEMENTS

All lease or rent arrangements occurring after 2/23/77 shall be limited to the owner's historical cost of ownership. For lease or rent arrangements occurring prior to 2/23/77, the Medicaid Program shall determine the allowable costs of the arrangement based on the general reasonableness of costs.

SECTION 720. ALLOWABLE COST BASIS ON PURCHASE OF FACILITY AS AN ONGOING OPERATION

The allowable cost basis of a facility purchased as an ongoing operation after July 1, 1976, shall be determined in accordance with the policies outlined 907 KAR 1:025..

SECTION 730. INTEREST EXPENSE - EXCEPTION TO BORROWER-LENDER RELATIONSHIP

Exceptions to the general rule regarding interest on loans from controlled sources of funds shall be made in the following circumstances. Interest on loans to facilities by partners, stockholders, or related organizations made prior to July 1, ·1975 shall be allowable as cost provided that the terms and conditions of payment of the loans have been maintained in effect without modification subsequent to July 1, 1975.

SECTION 740. REIMBURSEMENT FOR SERVICES OF PHYSICIANS, DENTISTS AND HOSPITALS

If physician (excluding psychiatry) or dental services are provided by an employee or if physician, dental or hospital services are provided under an ongoing contractual arrangement, all reasonable costs including direct resident services shall be recognized as routine service facility costs and shall not be billed to the Medicaid Program directly by the physician, dentist, or hospital. This provision shall apply only to staff personnel while performing services that are in the scope of their employment or contractual agreement with the facility.

SECTION 750. EDUCATIONAL COST

The cost associated with providing educational services to residents of ICF-IIDs shall not be an allowable expense for reimbursement purposes. Education services provided in facilities or areas within an ICF - IID or on its property which are specifically identified for providing these services by or under contract with the state or local educational agency shall not be reimbursable. Examples of these costs are salaries, building depreciation costs, overhead, utilities, etc. Whether or not educational services are provided in a specifically identified facility or area, reimbursement shall not be available for education or related services provided to a client during the periods of time the Individual Education Plan (IEP) requires that educational and related services be provided. All the services described in the IEP shall be excluded for Medicaid reimbursement, whether provided by state employees, by staff of the ICF-IID or by others.

Related services may be reimbursed if the services are performed as a reinforcement and continuation of the same type of instruction before or after the formal training as part of the individual's program of active treatment.

Educational services not eligible for reimbursement shall be those which are:

A. Provided in the building, rooms, or area designated or used as a school or educational facility;

B. Provided during the specific hours and time periods in which the educational instruction takes place in the normal school day and period of time for these students;

C. Included in the JEP for the specific student or required by Federal and State educational statutes or regulations; and,

D. Related services provided to a student under twenty-two (22) years of age.

SECTION 760. PURCHASE AND DISPOSAL OF SPECIALIZED MEDICAL EQUIPMENT

A. Specialized medical equipment such as eyeglasses, dentures, adaptive wheelchairs, etc., shall be a part of routine cost when purchased by the provider. These items shall be either expensed in the year of acquisition when appropriate or capitalized and depreciated when meeting the criteria for the acquisitions. Examples of items to be expended shall be most eyeglasses, dentures and other such items. Items to be capitalized and depreciated shall be adaptive wheelchairs, braces if applicable, etc. If an individual resident's family wishes to purchase any of these items for the resident, they may do so but any reimbursement to the facility shall be offset against the cost of the equipment to the extent the cost is reported on the facility's books.

B. When a resident is discharged or voluntarily leaves a facility, the specialized equipment may be taken by the resident. If the facility charges the resident for the equipment and the equipment was originally expensed, this revenue shall be offset against the cost of medical supplies or administrative and general cost in the period when the resident leaves. If the equipment was capitalized and depreciated, then the transaction shall be handled as any disposable of appreciable asset would be. However, the facility does not charge the resident for the equipment when they leave, then any remaining depreciation shall be included in the period when the discharge occurred.

SECTION 770. INTRODUCTION TO INSTITUTIONS FOR MENTAL DISEASES

A. This payment system is designed for the publicly operated cost-based nursing facilities defined as Institutions for Mental Disease (IMDs) which are providing services to Medicaid recipients and are to be reimbursed under the Department for Medicaid Services. This reimbursement system shall become effective with the rate setting on July 1, 1991.

B. The cost report submission requirements and the rate computation methodology effective July 1, 199l shall be the same as those for other cost-based facilities.

C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by IMD facilities.

SECTION 780. DEFINITION

For purposes of this system, an IMD is a publicly operated cost-based facility primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Coverage shall be limited to individuals age sixty-five (65) and above.

SECTION 790. INTRODUCTION TO DUAL LICENSE PEDIATRIC FACILITIES

A. This payment system shall be designed for dual licensed pediatrics facilities that are providing services to Medicaid recipients and shall be reimbursed by the Department for Medicaid Services.. This reimbursement system shall be effective with the rate setting on July 1, 1991.

B. The cost report submission requirements and the rate computation methodology rates effective July 1, 1991 shall be the same as those for all other cost-based facilities.

C. The intent of this reimbursement system shall be to recognize the reasonable costs associated with the services and level of care provided by Dual License Pediatric Facilities.

SECTION 800. DEFINITION

A facility having Dual Licensed Pediatric Facility beds and providing pediatric care only shall be classified as a pediatric Dual Licensed facility and shall receive reimbursement in accordance with the payment mechanism developed for that class of facility.

SECTION 810. INTRODUCTION TO THE COST-BASED FACILITY COST REPORT

The Annual Cost-Based Facility Cost Report provides for the submission of cost and statistical data which shall be used in rate setting and in reporting to various governmental and private agencies. All required information is pertinent and shall be submitted as accurately as possible.

In general, costs shall be reported as they appear in the provider's accounting records. Schedules shall be provided for any adjustments or reclassifications that are necessary.

In the cost finding process, direct costing between Certified Cost-Based Facility and Non-certified Cost-Based Facility shall be used wherever possible. If direct costing is utilized, it shall be utilized, if possible, for all costs of a similar nature. Direct costing shall not be utilized on a selective basis in order to distort the cost finding process.

SECTION l. SCHEDULE A - CERTIFICATION AND OTHER DATA;

This schedule shall be completed by all facilities.

A. TYPE OF CONTROL. Sections 1 through 3 indicate as appropriate the ownership or auspices under which the facility operates.

B. Section B is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the vendor by organizations related to the vendor by common ownership or control. Section B shall be completed by all vendors.

C. Section C shall be completed when the answer in Part B is yes. The amount reported in Section C shall agree with the facility's books.

D. Section D shall be completed when the answer in Part B is yes.

E. Section E is provided to show the total compensation paid for the period to sole proprietors, partners, and corporation officers, as owner(s) of Certified Nursing Facilities. Compensation is defined in the Principles of Reimbursement as the total benefit received (or receivable) by the owner for the services he renders to the institution. It shall include salary

amounts paid for managerial, administrative, professional, and other services; amounts paid by the institution for the personal benefit of the owner; and the cost of assets and services which the owner receives from the institution and deferred compensation. List the name, title and function of owner(s), percent of workweek devoted to business, percent of stock owned, and total compensation.

F. Section F is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistance administrators. List each administrator or assistance administrator who has been employed during the fiscal period. List the name, title, percent of customary workweek devoted to business, percent of the fiscal period employed, and total compensation for the period.

G. Section G shall be completed by all providers.

H. Section H shall be completed by all providers.

SECTION 2. SCHEDULE B - STATEMENT OF INCOME AND EXPENSES:

If a facility has an income statement that provides the same detail as this schedule, this statement may be submitted in lieu of Schedule B. This schedule shall be prepared for the reporting period. During preparation, consideration shall be given to the following items:

A. Line 1. The amount entered on this line shall be the gross charges for services rendered to residents before reductions for charity, bad debts, contractual allowances, etc.

B. Line 2. Record total bad debts, charity allowances, contractual adjustments, etc. on this line. This line shall include the difference between amounts paid by the resident or 3rd party payor and the standard charge of the facility.

C. Line 3. Subtract line 2 from line 1.

D. Line 4. Enter total operating expenses from Schedule D-4, Line 26, Column 2.

E. Line 5. Subtract line 4 from line 3.

F. Lines 6a, 6b, 7a, and 7b. Complete these lines in accordance with the definitions of restricted and unrestricted as presented in the Principles of Reimbursement in this manual.

G. Line 12. Include on this line rent received from the rental portions of a facility to other related er non-related parties, i.e., the rental of space to a physician, etc.

H. Line 14. Purchase discounts shall be applied to the cost of the items to which they relate. However, if they are recorded in a separate account, the total of the discounts shall be entered on this line.

I. Line 31. Total lines 6a through 30.

J. Line 33-48. Enter amount of other expenses, including those incurred by the facility, which do not relate to resident care.

K. Line49. Total lines 33 through 48.

L. Line 50. Subtract line 49 from line 32.

SECTION 3. SCHEDULE C-BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

Non-profit facilities shall complete only column 1 Proprietary facilities shall complete the entire schedule.

A. Column 1. Enter the balance recorded in the facility's books of accounts at the end of the reporting period (accrual basis of accounting is required as indicated in the Principles of Reimbursement). Attachments may be used if the lines on the schedule are not sufficient. The capital accounts shown on lines 41 through 45, are those applicable to the type of business organization under which the provider operates as follows:

Individual Proprietor - Proprietor's Capital Account
Partnership - Partner's Capital Accounts
Corporation - Capital Stock and Other Accounts

B. Column 2. This column shall be used to show amounts of assets and liabilities included in a facility's balance sheet, which do not relate to the provider of resident care. Entries to this column shall be detailed on

Schedule C-1. NOTE: It shall not be necessary to attempt to remove the portion of assets applicable to other levels of care on this schedule. Some examples of adjustments, which may be required, include:

1. Line 2 - Notes and Accounts Receivable. The notes and accounts receivable total to be entered in column 2 shall represent total amounts expected to be realized by the provider from non-resident care services.

2. Lines 11, 13, 15, 17, 19 - Fixed Assets. The amounts to be entered in column 2 shall be based on the historical cost of those assets, or in the case of donated assets, the fair market value at the time of donation, which are not related to resident care.

3. Line 12, 14, 16, 18, and 20- Accumulated Depreciation. The amounts in column 2 shall be the adjustment necessary to reflect accumulated depreciation on the straight-line method to the effective date of entry into this reimbursement program and amounts claimed thereafter, and shall also be adjusted for disposals and amounts of accumulated depreciation on assets not related to resident care. Assets not related to resident care shall be removed on lines 11, 13, 15, 17, and 19 respectively.

4. LINE 22 - INVESTMENTS. Investments includable in the equity capital balance sheet in column 3 shall be limited to those related to resident care. Primarily, these shall be temporary investments of excess operating funds. Operating funds invested for long periods of time shall be considered excess and not related to resident care needs and shall accordingly be removed in column 2.

5. LINE 25 - OTHER ASSETS. Examples of items which may be in this asset category and their treatment for equity capital purposes are as follows:

    a. Goodwill purchased shall be includable in equity capital.
    b. Organization Expense. Expenses incurred in organizing the business shall be includable in equity capital. (Net of Amortization)
    c. Discounts on Bonds Payable. This account represents a deferred charge to income and shall be includable in equity capital. Other asset amounts not related to resident care shall be removed in column 2.

6. LINES 37, 38 - LOANS FROM OWNERS. Do not make adjustments in column 2 with respect to funds borrowed by basic IC or IC/MR facilities prior to July 1, 1975 or by Skilled Nursing Facilities prior to December 1, 1979, provided the terms and conditions of the loan agreement have not been modified subsequent to July 1, 1975, or December 1, 1979, respectively. Such loans shall be considered a liability in computing equity capital as interest expense related to such loans is included in allowable costs.

   If the terms and conditions of payment of loans made prior to July 1, 1975 for IC facilities and December 1, 1979 for Skilled Nursing facilities, have been modified subsequent to July 1, 1975 and December I, 1979, respectively, such loans shall not be included as a liability in column 6, and therefore shall be adjusted in column 5. Loans made by owners after these dates shall also treated in this manner.

C. For Schedule C, line 1-45, adjust the amounts entered in column 1 (increase and decrease) by the amounts entered in column 2 and extend the net amounts to column 3. Column 3 is provided for the listing of the balance sheet amounts that represent equity capital for the Department for Medicaid Services purposes at the end of the reporting period.

SECTION 4. SCHEDULE C-1 - ADJUSTMENT TO EQUITY CAPITAL

This schedule shall be used to explain all adjustments made by the facility on Schedule C, column 2, in order to arrive at the adjusted balance sheet for equity capital purposes.

SECTION 5. OVERVIEW OF THE ALLOCATION PROCESS - SCHEDULE D - 1 THROUGH D - 5

These schedules provide for separating the operating expenses from the facility's financial records into five (5) cost categories: 1) Nursing Services Costs, 2) Other Care Related Costs, 3) Other Operating Costs, 4) Capital Costs and 5) Ancillary Costs. These schedules also provide for any necessary adjustments and reclassifications to certain accounts. Schedules D-l through D-5 shall be completed by all facilities. All accounts that can be identified as belonging to a

specific cost center shall be reported to the appropriate section of Schedules D-1 through D-5. Capital cost shall be reported on schedule D-4 and not allocated to specific cost centers.

All listed accounts will not apply to all providers and some providers may have accounts in addition to those listed. These shall be listed on the lines labeled "Other Expense."

The flow of the Schedules D-1 through D-4 is identical. Salaries shall be reported on the salary lines and all salaries for each cost center shall be sub-totaled on the appropriate line. The entries to the columns on these schedules shall be as follows:

A. Column 2. The expenses in this column shall agree with the provider's accounting books and records.

B. Column 3. This column shall be utilized for reclassification of expenses as appropriate. Such reclassifications shall be detailed on Schedule D-6.

C. Column 4. This column shall be for adjustments to allowable costs as may be necessary in accordance with the general policies and principles. All adjustments shall be detailed on Schedule D-7.

D. Column 5. Enter the sum of columns 2, 3, and 4,

E. Column 6. This column shall be completed for each line for which an entry is made to column 5 in order to indicate the basis of the separation of the costs reported to Column 5 between Column 7 (Certified Cost based facility Alloc. of Costs) and Column 8 (Non-Certified and Non-Cost-based facility Alloc. of Costs). A "D" shall be entered to this column on each line on which the adjusted costs (Column 5) are direct costed between Columns 7 and 8. An "A" shall be entered to this column on each line on which the adjusted costs in Column 5 are allocated between Columns 7 and 8 on the basis of the allocation ratios on Schedule F. All accounts which can be direct costed from the provider's records shall be directed costed to Columns 7 and 8. Accounts which are direct costed shall be direct costed in full. Any accounts which cannot be direct costed shall be allocated using statistics from Schedule F. Providers shall ensure that all costs which are reported to column 7 are reasonable, necessary and related to Certified Cost-based facility resident care.

F. Columns 7 and 8. The adjusted balance figures from Column 5 are to be allocated between Certified Cost-based Facility Costs (Column 5) and Non-Certified Non-Facility costs (Column 7). Any accounts that cannot

be direct costed shall be allocated using statistics from Schedule F. All costs entered to Column 7 shall be reviewed by the provider to ensure that they are necessary, reasonable and related to Certified Cost-based facility resident care.

G. Column 9: This column shall be completed only by Hospital-Based providers. Instructions regarding this column can be found in the instructions for the Schedules, which include Column 9 (i.e. D-3 and D-4).

SECTION 6. SCHEDULE D-1 - NURSING SERVICES COST

A. The costs associated with nursing services, which shall be included in the nursing service cost category, are as follows:

1. Nursing assessment of the health status of the resident and planning of appropriate interventions to overcome identified problems and maximize resident strengths;

2. Bedside care and services;

3. Administration of oral, sublingual, rectal and local medications topically applied, and appropriate recording of the resident's responses;

4. Training, assistance, and encouragement for self-care as required for feeding, grooming, ambulation, toilet, and other activities of daily living including movement within the nursing home facility;

5. Supportive assistance and training in resident transfer techniques including transfer from bed to wheelchair or wheelchair to commode;

6. Care of residents with behavior problems and severe emotional problems requiring nursing care or supervision;

7. Administration of oxygen;

8. Use of nebulizers;

9. Maintenance care of resident's colostomy, ileostomy, and urostomy;

10. Administration of parenteral medications, including intravenous solutions;

11. Administration of tube feedings;

12. Nasopharyngeal aspiration required for maintenance of a clean airway;

13. Care of suprapubic catheters and urethral catheters;

14. Care of tracheostomy, gastrostomy, and other tubes in a body;

15. Costs of equipment and supplies that are used to complement the services in the nursing service cost category including incontinence pads, dressings, bandages, enemas, enema equipment, diapers, thermometers, hypodermic needles and syringes, and clinical reagents or similar diagnostic agents;

16. Costs for education or training including the cost of lodging and meals of nursing service personnel;

17. The salaries and wages of persons performing nursing services including salaries of the director, and assistant director of nursing, supervising nurses, medical records personnel, registered professional nurses, licensed practical nurses, nurse aides, orderlies, and attendants;

18. The salaries or fees of medical directors, physicians, or other professionals performing consulting services on medical care which are not reimbursed separately on a fee for service basis; and

19. The costs of travel necessary for training programs for nursing personnel required to maintain licensure, certification, or professional standards.

B. If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Nursing Facility Costs). Any account that is direct costed shall be directed costed in full. Any account which cannot be direct costed shall be allocated using Schedule F, Statistic A. Multiply the Column 5 amount by the Certified Cost-based facility percentage from Schedule F, Statistic A, and enter the product in Column 7. Subtract Column 7 from Column 5 and enter the result in Column 8. Providers shall ensure that all costs reported to Column 7 are necessary, reasonable, and related to Certified Cost-based facility resident care.

SECTION 7. SCHEDULE D-2 - OTHER CARE RELATED COSTS

A. General

The costs that shall be reported in the other care-related services cost category include:

1. Food costs, not including preparation;

2. Direct costs of other care-related services, such as social services and resident activities;

3. The salaries and wages of activities directors and aides, social workers and aides, and other care related personnel including salaries or fees of professionals performing consultation services in these areas which are not reimbursed separately under the Medicaid Program;

4. The costs of training including the cost of lodging and meals to meet the requirements of laws or rules for keeping an employee's salary, status, or position, or to maintain or update skills needed in performing the employee's present duties.

B. Specific Instructions

1. Lines 1-30: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non- Certified and Non- Cost-based facility Costs.) Any account which is direct costed shall be direct costed in full. If accounts cannot be direct costed use the nursing allocation percentage (Schedule F, Statistic A, Line 3) to calculate Certified Nursing Facility Other Care Related Costs. Multiply the Certified Cost-based facility percentage times the amount in Column 5 and enter the products in Column 7. Subtract Column 7 from Column 5 and enter the results in Column 8.

2. Line 31 : If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non- Certified and Non-Cost-based facility Costs.) Any account, which is direct, costed between Certified Cost-based facility and Non-Certified Cost-based facility shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the dietary allocation percentage (Schedule F, Statistic C, Line 1, Column 2). Multiply the Certified Cost-based facility percentage times the amount in Column 5 and enters the product in Column 7.

Subtract the amount in Column 7 from Column 5 and enter the result in Column 8.

SECTION 8. SCHEDULE D-3 - OTHER OPERATING COSTS

A. Lines 1 through 19: If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7. Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost- based facility Costs.) Any account, which is direct costed, shall be direct costed in full. If an account cannot be direct costed, use the dietary allocation percentage (Schedule F, Statistic C. Line I, and Column 2) to allocate Dietary Costs. Multiply the Certified Cost-based facility percentage times the amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

B. Lines 21 through 55: [-] If an account can be direct costed, between Certified Cost-Based Facility and Non-Certified Cost-Based Facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) either Column 7, Certified Cost-Based Facility Costs, or Column 8, Non-Certified and Non- Cost-Based Facility Costs.) Any account, which is direct costed, shall be direct costed in full. Any account that cannot be direct costed shall be allocated using the Certified Cost-based facility square foot percentage (Schedule F, Statistic B, Line I, and Column 2). Multiply the percentage times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage (Schedule F, Statistic B, Line 2, and Column 2) times the amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square foot percentages (Schedule F, Statistic B, Lines 3 through 8, Column 2) together. Use the sum to allocate Housekeeping & Plant Operation costs of the ancillary cost centers to Column 9.

C. Line 57 through 74 and 76 through 130: [] If an account can be direct costed between Certified Cost-based facility and Non-Certified Cost-based facility the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s), (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified

and Non-Cost-Based Facility Costs.) If an account cannot be direct costed, use the nursing allocation percentage (Schedule F, Statistic A, Line 3) to calculate Certified Cost-Based Facility Laundry and Administrative & General costs. Multiply the Certified Cost-Based Facility percentage times amounts in Column 5 and enter the products in Column 7. Subtract the amounts in Column 7 from Column 5 and enter the results in Column 8.

SECTION 9. SCHEDULE D-4 - CAPITAL COSTS

A. If an account can be direct costed, between Certified Cost-based facility and Non-Certified Cost-based facility, the amount carried to Column 5 (Adjusted Balance) shall be direct costed in the appropriate amount(s) to the proper column(s) (either Column 7, Certified Cost-based facility Costs, or Column 8, Non-Certified and Non-Cost-based facility Costs.) If an account cannot be direct costed, allocate capital costs using square footage (Schedule F, Statistic B, Column 2). Multiply the Certified Cost- based facility percentage on Line 1 times amounts in Column 5 and enter the products in Column 7. Multiply the "Other" percentage on Line 2 times amounts in Column 5 and enter the products in Column 8. For Hospital-Based Facilities only: add the ancillary square footage percentages from Schedule F, Statistic B (Lines 3 through 8, Column 2) together. Use the sum to allocate capital costs of the ancillary cost centers to Column 9.

B. Lines 24 through 28 are provided for the computation of total costs per books, net reclassifications, net adjustments, and total adjusted costs for comparison and analysis.

    1. Line 24: The entries to this line Columns 2 through 9 shall be the total of the entries to Columns 2 through 9 of Schedules D-1 through D-3 and D-4 through Line 22.

    2. Line 25, Column 7: The entry to this line shall be the sum of Schedule D-5, Column 8, Lines 12, 21, 30, 42, 51, 60, and 67.

    3. Line 26, Column 7: The entry to this line shall be the sum of Column 7, Lines 24 and 25.

    4. Line 27: The entries to this line columns 2 through 5 shall be the total of the entries to columns 2 through 5 of Schedule D-5. Add the entries from the appropriate column, Schedule D-5, Lines 12, 21, 30, 42, 51, 60 and 67 to compute the proper entry.

5. Line 28: The entries to this line shall be the totals of lines 24 and 27.

    a. Column 2: The amount entered to Line 26, Column 2 shall agree with the total costs of the facility as reported in its general ledger.
    b. Column 3: The total reclassifications (the amount entered to Line 26, Column 3) shall net out to be zero (0).
    c. Column 4: The amount entered to Line 26, Column 4 shall be the total of all adjustments entered to Scheduled D-1 through D-5. It shall agree with the total adjustments reported on Schedule D-7 (D-7, Line 53, Column 3).

SECTION 10. SCHEDULE D-5- ANCILLARY COSTS

A. Column 2: Ancillary costs as shown in the provider's books shall be entered to the appropriate lines. All ancillary salaries shall be reported to the salaries lines and sub-totaled on the appropriate line.

B. Column 3: This column shall be utilized for reclassification of Column 2 costs as may be necessary for compliance with the general policies and principles. Reclassifications shall be detailed on Schedule D-6.

C. Column 4: This column shall be utilized for adjustments to allowable ancillary costs as may be necessary for compliance with the general policies and principles. Adjustments shall be detailed on-Schedule D-7.

D. Column 5: Enter the sum of Columns 2, 3, and 4. The amount entered here shall be the total ancillary cost of the facility as defined by the general policies and procedures.

E. Column 6: The cost entered to Column 5 shall be analyzed to identify the direct and indirect ancillary cost portions as defined in the general policies and principles. The direct ancillary Cost shall be entered to Column 6.

F. Column 7: This column shall be utilized to report the indirect ancillary portion (as defined in the general policies and principles) of the amount entered to Column 5. Subtract Column 6 from Column 5 and enter the difference.

1. Lines 11, 20, 29, 41, 50, 59, and 66 shall be completed by Hospital- Based Providers only. The purpose of these lines shall be to compute each ancillary cost center's share of plant operations and maintenance, housekeeping and capital costs. The Column 7 amounts are derived by multiplying the appropriate Hospital Ancillary Square Foot Percentage (Schedule F, Statistic B, Column 4) by the amount on Schedule D-4, Line 24, Column 9.

G. Column 8: This column shall be used for reporting the Certified Cost Based Nursing Facility's share of indirect cost. For each ancillary cost center, multiply the appropriate Certified Cost-based facility Ancillary Charge Percentage (Schedule F, Statistic D, Column 3) times the amounts reported in Column 7 to arrive at the correct amounts for Column 8.

SECTION 11. SCHEDULE D-6-RECLASSIFICATION OF EXPENSES

This work sheet provides for the reclassification of certain amounts necessary to effect proper cost allocation under cost finding. All providers that do not direct cost payroll fringe benefits to individual cost centers shall use this schedule to allocate fringe benefits to the various cost centers. Fringe benefits shall be reclassified to individual cost centers on the ratio of the salaries unless another, more accurate and documentable method can be determined. The reclassification to each cost center shall be entered to the appropriate Schedule D-1 through D-5 line titled" Employee Benefits Reclassification."

SECTION 12. SCHEDULE D - 7-ADJUSTMENT TO EXPENSES

This schedule details the adjustments to the expenses listed on Schedule D-1 through D-5, column 4. Line descriptions indicate the nature of activities, which affect allowable costs as defined in this manual or result in costs incurred for reasons other than resident care, and thus require adjustment. Lines 22 through 52 are provided for other adjustments not specified earlier. A brief description shall be provided.

The adjusted amount entered in Schedule D-7, column 3, shall be noted "A" in Schedule D-7, column 2, when the adjustment is based on costs. When costs are not determinable, "B" shall be entered in column 2 to indicate that the revenue received for the service is the basis for the adjustment.

SECTION 13. SCHEDULE E-ANCILLARY SETTLEMENT

This schedule is designed to determine the Medicaid share of direct and indirect ancillary costs.

A. Column 2: Enter direct ancillary cost for each ancillary cost center from Schedule D-5, Column 6.

B. Column 3: Multiply the direct costs (Column 2) by the corresponding Medicaid charge percentages (Schedule F, Section D, Column 5, Lines 1 through 7).

C. Column 4: Enter the total amount received from the Medicaid Program (including any amount receivable from the Medicaid Program at the report date) for ancillary services rendered to Medicaid Certified Cost-based facility recipients during the period covered by the cost report.

D. Column 5: Subtract the Column 5 amount from the Column 4 amount and enter the difference in Column 6.

SECTION 14. SCHEDULE F -ALLOCATION STATISTICS

A. Section A - Nursing Hours or Salaries

This allocation statistic shall be used as the basis for allocating the line item costs reported to Schedule D- 1, Lines 1-33; Schedule D-2, Lines 1- 30; and D-3, Lines 57-130, which cannot be direct, costed to the levels of care. The allocation statistic may be based on the ratio of direct cost of nursing salaries, the ratio of direct nursing hours, a valid time study (as defined by the Department for Medicaid Services), another method which has been approved by the Department for Medicaid Services or, if no other reasonable basis can be determined, resident days. The computation of this statistic shall account for the direct salary costs associated with all material non-certified nursing activities of the facility (such as adult day care or home health services, for example). The computed statistic shall be reasonable and based on documented data. The method used in arriving at the allocation shall be identified at the appropriate place on Schedule F, Ratio A. For Hospital-Based Facilities Only: The salary costs of all departments and services of the hospital, including all ancillary departments as defined in the general policies and principles of the

Department for Medicaid Services, shall be included in the calculation of this statistic. Allocations of costs between Certified Cost-based facility and acute cost centers on the basis of resident days will be accepted only when the resulting allocation statistic can be documented and shown to be reasonable.

1. Line 1: Enter the Certified Cost-based facility figure (i.e., salaries or direct hours)
2. Line 2: Enter the 'Other" nursing and direct service figure (i.e. salaries or direct hours)
3. Line 3: Divide Line 1 by the sum of Lines 1 and 2 and enter the percentage on Line 3. The percentage shall be carried out to four decimal places (i.e. xx.xxxx%).
4. NOTE: If salary cost figures are used in computing this allocation statistic, the amounts entered in Lines 1 and 2 shall usually agree to entities on the salary lines of Schedule D-1. If the Schedule F, Ratio A salary figures do not agree to Schedule D-1 salary lines, providers shall review both schedules to ensure that both schedules are correct. The provider shall be able to reconcile Schedule F, Ratio A to Schedule D-1 salary lines upon request.

B. Section B - Square Footage

1. Freestanding facilities shall only complete Columns 1 and 2 of this section. Hospital facilities shall complete all four columns.

    a. Column I, Lines 1-10: Enter the square feet in each applicable area of the facility. Direct resident room areas shall be allocated between Certified Cost-based facility and "Other" (PC, Non-certified, Acute, etc.). General resident areas, such as hallways, nursing stations, lounges, etc., which are utilized 100% by one level of care shall be directly allocated to the appropriate cost center. General resident areas used by more than one level of care and general service departments (administrator offices, dietary areas, etc,) shall be allocated between levels of care based on the ratio of Certified Cost-based facility room square footage to total room square footage. In freestanding facilities, ancillary departments shall be

considered general service departments and allocated to levels of care. In Hospital-Based facilities, direct ancillary square footage shall be entered on Lines 3 through 8.

b. Column 2, Lines 1-10: Percentages in Column 2 shall be derived by dividing Column 2, Lines 1 through 9 by Line 10 of Column 1. Line 10 shall be the sum of Lines 1 through 9 and should equal 100.0000%.

2. Columns 3 and 4 shall only be completed by Hospital-Based Facilities. These two columns compute allocation factors to allocate the indirect ancillary costs allocated to the pooled ancillaries in Column 9 of Schedules D-3 and D-4 to the individual ancillary cost centers on Schedule D-5.

   a. Column 3, Lines 3-9: The entries to these lines shall be identical to the entries on the same line number of Ratio B, Column l.
   b. Column 3, Line 10: The entry to this line shall be the sum of the entries to Lines 3-9.
   c. Column 4, Lines 3-9: The entries to these lines shall be the percentages resulting from dividing the direct square footage allocated to each ancillary service in Column 3, Lines 3-9 by the total direct ancillary square footage computed at Column 3, Line 10. Percentages shall be carried to four digits (i.e., xx.xxxx¾).
   d. Column 4, Line 10: The entry to this line shall be the sum of Column 4, Lines 3-9 and shall equal 100.0000%.

C. Section C – Dietary

Identify the method used in arriving at the number of meals served. An actual meal count for 3 X in resident days shall be used. If 3 X in resident days is used, the provider shall ensure that bed reserve days are not included in this calculation.

1. Column 1: Enter total meals in each category.
2. Column 2: To arrive at percentages, divide Lines 1 and 2 in Column I by Line 3 in Column 1.

D. Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines 1 through 7. Add Lines 1 through 7 and enter total on Line 8.
2. Column 2: Enter the total charge for each type of ancillary service provided to all Certified Cost-based facility residents (both Medicaid and non-Medicaid) on Lines 1 through 7. Add Lines 1 through 7 and enter the sum to Line 8.
3. Column 3: For each Line 1 through 8 divide total CNF resident charges as reported in Column 2 by the total resident charges (all facility residents) reported in Column 1. Enter the resulting percentage in column 3. Percentages shall be carried to four decimal places (i .e, xx.xxxx%).
4. Column 4: Enter the total charges for each type of ancillary service provided to Medicaid residents in certified beds on Lines l through 7. Add Lines 1 through 7 and total on Line 8.
5. Column 5. For each Line 1 through 8 divide Medicaid charges in Column 4 by total charges in Column 1. Enter the resulting percentage in Column 3. Percentages shall be carried out to four decimals (i.e. xx xxxx%).

E. Section E - Occupancy Statistics

1. Lines 1 and 2. Enter the number of licensed bed days. Temporary changes due to alterations, painting, etc. do not affect bed capacity.
2. Line 3. Total licensed bed days available shall be determined by multiplying the number of licensed beds in the period by the number of days in the period. Take into account increases and decreases in the number of licensed beds and the number of days elapsed since the changes. If actual bed days are greater than licensed bed days available, actual bed days shall be used.
3. Line 4. Enter resident days for all residents in the facility. A resident day shall be the care of one resident during the period between one census taking period on two successive days, including bed reserve days. The day of admission shall be included and the day of discharge excluded. Do not include both. When a resident is admitted and discharged on the same day, this period shall be counted as one day.

4. Line 5. Percentage of occupancy shall be the percentage obtained by dividing total resident days by bed days available. The percentage calculation shall not be carried beyond one decimal place (xx.x¾).
5. Line 6. A Medicaid resident day of care shall be an in-resident or bed reserve day covered under the Medicaid Program. A resident days covered by the Medicare Program for which a co-insurance or deductible is made by the Medicaid Program

INSERT SCREENSHOTS OF THE COST REPORT SCHEDULES HERE