X. Home Health Agency Services

(1) The following home health services are paid in accordance with a fee schedule established by the state Medicaid agency, not to exceed billed charges:

Skilled Nursing
Home Health Aide
Medical Social Service
Physical, Occupational and Speech Therapy

(2) Enteral nutritional products and disposable medical supplies shall be reimbursed based on costs as submitted on an annual cost report. Providers shall be paid an interim rate determined by multiplying a provider's facility-specific cost to charge ratio by its billed charges. Interim payments shall not exceed submitted charges and will be settled back to actual cost at the end of the home health agency's fiscal year, subject to lower of costs or charges. Interim payments will be settled back to allowable cost within 18 months following the end of the agency's fiscal year. Allowable costs will be based on audited or desk reviewed cost reports and determined in accordance with Medicare reimbursement principles. Cost reports for each of the home health agencies described in sections (3), (4), and (5) must be received by the Department within five (5) months of the close of the agency's fiscal year (May 31).

Public providers will not be subject to the lower of cost or charges and will be reimbursed their total allowable cost for enteral nutritional and disposable medical supplies.

(3) Payment to a new home health agency for the services described in (1) will be in accordance with the methodology described in (1). New home health agencies will be paid for enteral nutritional products and disposable medical supplies on an interim basis by multiplying their billed charges for these products by seventy (70) percent. A new home health agency will be held to the seventy (70) percent threshold until a cost report is received by the state Medicaid agency. A home health agency that did not participate under the current ownership or a previous ownership in the prior year will be considered a new home health agency. A new home health agency will be reimbursed as described above until a cost report is received by the department, no later than May 31 prior to the rate year beginning July 1.

(4) Payment to an out of state home health agency for the services described in (1) will be in accordance with the methodology described in (1). Out of state agencies will be paid for enteral nutritional products and disposable medical supplies by multiplying billed charges by eighty (80) percent.

(5) For home health services provided by licensed county health department home health agencies, a supplemental payment which represents the difference between the estimated costs of home health services for the eight month period beginning November 1, 2002 and ending June 30, 2003 and the amount of payments made by the Department for these services under the flat fee reimbursement as describe in (1) will be made.

Using cost reports filed with the Department, the Department will calculate the unit cost for a service listed under (1) and compare the unit cost to the rate per unit as described in (1). The supplemental payment will equal the difference between the cost per unit of service multiplied by the number of units of service provided during the period. In this way, the Department shall assure public providers reimbursement for their total allowable costs.

If a provider's costs as estimated from the annual cost report are less than the estimated payments, the Department will recoup any excess payments.

(6) Services provided by County Health Department Home Health Agencies. For the fiscal period beginning July 1, 2003 and for subsequent periods beginning July 1, supplemental payments will be made on a quarterly basis. The supplemental payments will be compared to the provider's annual cost report and adjustments made as described in (5) above.

8. Private Duty Nursing Services

DMS will reimburse for private duty nursing services at a rate of nine dollars per fifteen minutes. DMS will not reimburse for more than ninety-six units per recipient per twenty-four hour period or 8,000 units per twelve-consecutive month period per recipient.

XI. Laboratory Services

Eff. The state agency will reimburse participating independent laboratories, outpatient surgical clinics, renal dialysis centers, and outpatient hospital clinics 62% of the current Medicare Clinical Laboratory Fee Schedule.

XII For services provided on or after July 1, 1990, physician (clinical diagnostic) laboratory services shall be reimbursed 60% of the current Medicare Clinical Laboratory Fee Schedule. For laboratory services with no established allowable payment rate, the payment shall be sixty-five (65) percent of the usual and customary actual billed charges.

XIII Family Planning Clinics

Effective 7/1/87, the State Agency will reimburse participating family planning agencies for covered services in accordance with 42 CFR 447.32. Payments to physicians and Advanced Registered Nurse Practitioners (ARNP) for individual services shall be reimbursed the lesser of the actual billed amount or the below listed amounts:

| | Physicians | ARNP |
|---|---|---|
| Initial Clinic Visit | $50.00 | $37.75 |
| Annual Clinic Visit | $60.00 | $45.00 |
| Follow-up Visit with Pelvic Examination | $25.00 | $18.75 |
| Follow-up Visit without Pelvic Examination | $20.00 | $15.00 |
| Counseling Visit | $13.00 | $13.00 |
| Counseling Visit w/3 months contraceptive supply | $17.00 | $17.00 |
| Counseling Visit w/6 months contraceptive supply | $20.00 | $20.00 |
| Supply Only Visit – Actual acquisition cost of contraceptive supplies dispensed | | |

XIV. Durable Medical Equipment, Supp, Prosthetics and Orthotics

1. General DME Items

For DME items that have an HCPC code (except for customized items) reimbursement shall be based on the Medicaid fee schedule, not to exceed the supplier's usual and customary charge.

2. Manual Pricing of DME Items

a. Customized items with a miscellaneous HCPC code of K0108 will require prior-authorization and will be reimbursed at invoice minus twenty- two (22) percent, not to exceed the supplier's usual and customary charge.

b. Customized components that do not have a HCPC code, and all other miscellaneous codes will require prior-authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary change.

c. DME items that do not have HCPC codes and have been determined by the department to be covered will require prior authorization and will be reimbursed at invoice plus twenty (20) percent, not to exceed the supplier's usual and customary charge.

d. Specialized wheelchair bases with codes of K0009 and K0014 will require prior authorization and will be reimbursed at manufacturers suggested retail price minus fifteen (1 5) percent, not to exceed the supplier's usual and customary charge.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Other diagnostic, screening, preventive and rehabilitative services provided by licensed community mental health centers, and other mental health and substance use providers shall be reimbursed as outlined below:

1. Community Mental Health Centers (CMHCs) are paid CMHC-specific cost-based rates per service based on the type of practitioner rendering the service. For the period beginning January 1, 2014, the rates are those in existence for the practitioners in CY 2013. Separate rates are set for the following practitioners:

    - Licensed Psychologist (LP)
    - Licensed Psychological Practitioner (LPP)
    - Licensed Clinical Social Worker (LCSW)
    - A psychiatric social worker with a master's degree from an accredited school
    - Licensed Professional Clinical Counselor (LPCC)
    - Licensed Professional Art Therapist (LPAT)
    - Licensed Marriage and Family Therapist (LMFT)
    - Licensed Behavior Analyst (LBA)
    - Psychiatrist
    - Physician
    - A psychiatric nurse licensed in the state of Kentucky with one of the following combination of education and experience:
        i. Master of Science in Nursing with a specialty in psychiatric or mental health nursing. No experience required.
        ii. Bachelor of Science in Nursing and one (1) year of experience in a mental health setting.
        iii. A graduate of a three-year educational program with two (2) years of experience in a mental health setting.
        iv. A graduate of a two-year educational program (Associate degree) with three (3) years of experience in a mental health setting.
    - Licensed Alcohol and Drug Counselor (LADC)
    - Licensed Alcohol and Drug Counselor Associate*(LADCA)
    - A professional equivalent, through education in a behavioral health field and experience in a behavioral health setting, qualified to provide behavioral health services.
    - The following professionals under the appropriate supervision:
        i. A mental health associate with a minimum of a Bachelor's degree in psychology, sociology, social work, or human services under supervision of one of the above professionals;
        ii. A licensed psychological associate;
        iii. A licensed professional counselor associate;
        iv. A licensed professional art therapist associate;

XVI. Other diagnostic, screening, preventive and rehabilitative services.

ix. Peer Support Specialist working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, or a LPATA ;

x. A certified alcohol and drug counselor (CADC) working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a LPAT, or a LPATA; and

xi. A community support associate who is working under the supervision of a physician, a psychiatrist, an APRN, a PA, a LP, a LPP, a LPA, a LCSW, a LMFT, a LPCC, a CSW, a LMFTA, a LPCA, a CADC, a Professional Equivalent, a psychiatric nurse, a LPAT, a LPATA, a LBA, or a LABA.

The current reimbursement methodology, as outlined above, for services provided in CMHCs will end on June 30, 2016.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

The reimbursement described below is applicable to the following mental health and substance use disorder services.

- Screening
- Assessment
- Psychological Testing
- Crisis Intervention
- Residential Crisis Stabilization
- Day Treatment
- Peer Support
- Parent/Family Peer Support
- Individual Outpatient Therapy
- Group Outpatient Therapy
- Family Outpatient Therapy
- Collateral Outpatient Therapy
- Partial Hospitalization
- Service Planning
- SBIRT – Screening, Brief Intervention and Referral to Treatment (Substance use only)
- Medication Assisted Treatment (Substance use only)
- Comprehensive Community Support Services (Mental health & Co-occurring only)
- Therapeutic Rehabilitation Program (TRP) (Mental health only)

Reimbursement for the services listed above are based on the Kentucky specific Medicaid fee schedule, which can be found at http://chfs.ky.gov/dms/fee.htm and is effective beginning on January 1, 2014. The Medicaid fee schedule is based on the following methodology:

1. Physician Base Fee is calculated based on the following (in descending order of applicability):

(a) If a current Kentucky-specific Medicare rate exists for the service, physicians will be reimbursed at 75% of the current Kentucky-specific Medicare rate, as published by CMS on an annual basis, using 15 minute increments. This is calculated using the following methodology:

i The Mental Health and Substance Abuse rates start with the current standard Kentucky specific Non-Facility Medicare rate for a 60 minute service.

ii The 60 minute elapsed time rate is converted to a 15 minute rate to correspond to the Kentucky Medicaid reimbursement methodology of 15 minute units for traditional Medicaid and Mental Health providers.

iii The Kentucky Medicaid rate for physicians/psychiatrists is 75% of the current Kentucky-specific Medicare rate.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. All other mental health and substance use providers

(b) If a current Kentucky-specific Medicare rate does not exist, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky Medicaid reimbursement programs (with similar degrees of complexity). Kentucky has developed, based on Resource Based Relative Value Scale weighting where possible, and absent RBRVS metrics, a weighted average based comparison of charges, so that a service that Medicare has not priced generates a Medicaid rate to a physician that is "similar" to a rate for either a similar RVRBS metric or a similar percent of charges metric.

(c) If a current Kentucky-specific Medicare rate does not exist and the service is not similar to other Kentucky Medicaid reimbursed services, physicians will be reimbursed for the service based on the state's payment rates for similar services in other Kentucky programs that are not Medicaid reimbursed (i.e., funded only through State General Funds).

XVI. Other diagnostic, screening, preventive and rehabilitative services.

B. Other practitioners providing the service (listed in 1, 2, 3, 4, and 5 below) will be reimbursed based on a step down methodology calculated as a percentage of the physician rate (75% of the current Kentucky-specific Medicare rate, or the established Medicaid rate if a current Kentucky-specific Medicare rate does not exist). The step down includes:

(1) 85% - Advanced Practice Registered Nurse (APRN), Licensed Psychologist (LP)

(2) 80% - Licensed Professional Clinical Counselor (LPCC), Licensed Clinical Social Worker (LCSW), Licensed Psychological Practitioner (LPP), Licensed Marriage and Family Therapist (LMFT), Licensed Professional Art Therapist (LPAT), Licensed Behavior Analyst (LBA), Licensed Alcohol and Drug Counselor (LADC), Certified Alcohol and Drug Counselor (CADC).

(3) 70% - Licensed Psychological Associate (LPA), Licensed Marriage and Family Therapist Associate (LMFTA), Licensed Professional Counselor Associate (LPCA), Certified Social Worker, Masters Level (CSW), Physician Assistant (PA) working under the supervision of a physician, Licensed Professional Art Therapist Associate (LPATA), Licensed Assistant Behavior Analyst (LABA), Licensed Alcohol and Drug Counselor Associate (LADCA). The billing provider is either the supervisor, a provider group, or licensed organization.

(4) 50% - Bachelors-level providers

(5) 40% - Other non-bachelors-level providers

Partial hospitalization will be reimbursed a rate of $194.10 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate is posted at http://chfs.ky.gov/dms/fee.htm.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The partial hospitalization rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

3. Per 42 CFR 431.107, each provider or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

Residential Services for Substance Use Disorders will be reimbursed a rate of $230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar service.s The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Residential Services for Substance Use Disorders will be reimbursed a rate of $230 per day. In order to be reimbursed this rate, at least one service must be provided during the period. This rate will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year. This per diem was calculated by using Kentucky's EPSDT rate for similar facility services.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The residential services for substance use disorders rate is based on rates currently set for state plan services - Kentucky's EPSDT rate for similar facility services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Intensive outpatient program will be reimbursed on a per diem basis. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Intensive Outpatient Therapy. The agency's fee schedule rate was set as of December 2, 2015 and is effective for services provided on or after that date. All rates are published http://chfs.ky.gov/dms/fee.htm. This per diem was calculated by using Kentucky's existing rate for rehabilitative children in the custody of or at risk of being in the custody of the state or for children under the supervision of the state and converting it to a per diem for the same service.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The intensive outpatient program rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

XVI. Other diagnostic, screening, preventive and rehabilitative services.

Assertive Community Treatment will be reimbursed a rate of $750 per month for a four (4) person team, and $1,000 per month for a ten (10) person team. In order to be reimbursed this rate, at least one service must be provided during the period. These rates will be adjusted upward annually by the same percentage as the current Kentucky-specific Medicare rate adjustment at the beginning of each calendar year.

1. Kentucky has developed a method for allocating the portion of the rate related to each of the bundled services for purposes of proper reporting on the CMS-64.

2. The ACT rate is based on rates currently set for state plan services. The rates for each service are multiplied by the anticipated service frequency per day. Additionally, these rates do not include costs related to room and board or any other unallowable facility costs.

3. Per 42 CFR 431.107, each providers or organization furnishing these services shall keep any records necessary to disclose the extent of services the provider furnishes to beneficiaries and, on request, furnish the Kentucky Department for Medicaid Services any information maintained and any information regarding payments claimed by the provider for furnishing services under the plan. These records include documentation that at a minimum includes the following: date of service; name of recipient; Medicaid identification number; mane of provider agency and person providing the service; nature, extent or units of service; and the place of service." Kentucky will review the data in order to develop and revise as necessary, economic and efficient rates, and will explain how the data was used to develop the rates.

B. Effective for services provided on and after July 2, 2001, primary care centers will be reimbursed in accordance with the prospective payment system described in Attachment 4.19-B, page 20.16 for FQHCs and RHCs.

For drugs for specified immunizations provided free from the Health Department to primary care centers for immunizations for Medicaid recipients, the cost of the drugs are paid to the Health Department. The specified immunizations are: diphtheria and tetanus toxoids and pertuisis vaccine (DPT); measles, mumps, and rubella virus vaccine, live (MMR); poliovirus vaccine, live, oral (any type)) (OPV); and hemophilus B conjugate vaccine (HBCV).

Effective January 1, 1989, the cost for these immunizations will not be allowed as a part of the primary care center cost base so long as these drugs are available free from the Health Department.

For the period 10/01/02 through 6/30/04, adjusted payments will be made to Community Mental Health Centers to recognize and support their continued commitment to the provision of mental health services. These payments will be made on a quarterly basis and will reflect the difference in the costs used to determine current rates and Medicaid Costs determined as follows:

1. Using audited cost reports ending June 30, 2000, costs for the covered mental health rehabilitation services described in Attachment 3.1- A, page 7.6.1(a) and Attachment 3.1-B, page 31.5(a) will be allocated to the following cost centers: therapeutic rehabilitation, outpatient individual, outpatient group, outpatient psychiatry, outpatient/personal care home, outpatient/in-home setting, and hospital psychiatric (professional services provided in an inpatient setting).
2. The Medicaid percentage for each cost center will be determined by dividing Medicaid units of service by total units of service by cost center.
3. Medicaid costs per cost center will be determined by multiplying costs by the Medicaid percentage per cost center.
4. Medicaid costs per cost center will be inflated to the mid-point of the rate year using the Home Health Market Basket Index.
5. The increased Medicaid capital will be determined by multiplying any capital increase from the base year to the rate year by the aggregate Medicaid percentage. The aggregate Medicaid percentage is determined by dividing total Medicaid costs by total costs.
6. The difference between the base year Medicaid costs and the inflated Medicaid costs will be added to the increased Medicaid capital.
7. Costs shall be determined in accordance with cost principles outlined in the Provider Manual. Only Medicaid recognized costs will be included in the calculation.
8. These adjusted payments will expire on July 1, 2004.

Payment methodology for rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and that are provided through an agreement with the State Health or Title V agency.

A. Rehabilitative services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rates for rehabilitative services are negotiated rates between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of each service.

The payment rate for rehabilitative services that are authorized after June 30, 2002, are uniform rates, determined by 98% of the weighted median of claims for each service for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

B. Rehabilitative services for children under the supervision of the state and that are provided through an agreement with the State Health or Title V agency.

Payments for rehabilitative services covered in Attachment 3.1-A, page 7.6.1 and Attachment 3.1B, page 31.5 for the target populations are per service. They are based upon one or more documented rehabilitative services provided to each client. The rates for the rehabilitative services are based upon the actual direct and indirect costs to the providers. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing rehabilitative services based on financial information submitted by the provider.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: identification, by recipient and worker, of each individual service provided, a showing of all direct costs for rehabilitative services; and a showing of all indirect costs for rehabilitative services appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principle if necessary.

Rehabilitative service providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

XVII. FQHC/RHC Services

Reimbursement for Federally Qualified Health Centers (FQHCs ) and Rural Health Clinics (RHCs) shall be made in accordance with section 1902 of the Social Security Act as amended by section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement Act of 2000 (BIPA).

For the period of January 1, 2001 through June 30, 2001, the state will implement an alternative reimbursement methodology that is agreed to by the state and the individual center/clinic and results in a payment rate to the center/clinic that is at least equal to the Medicaid PPS rate. The alternative methodology shall be in accordance with the state plan in effect on December 31, 2000.

All FQHCs and RHCs are reimbursed on a prospective payment system beginning with State Fiscal Year 2002 with respect to services furnished on or after July 1, 2001 and each succeeding year.

Payment rates will be set prospectively using the total of the clinic/centers reasonable cost for the clinic/center's fiscal years 1999 and 2000, adjusted to take into account any increase or decrease in the scope of services furnished during the clinic/center's fiscal year 2001 and increased by an appropriate medical index. These costs are divided by the number of visits/encounters for the two-year period to arrive at a cost per visit. The cost per visit is the prospective rate for state fiscal year 2002. For each state fiscal year thereafter, each clinic/center will be paid the amount (on a per visit basis) equal to the amount paid in the previous state fiscal year, increased by the percentage increase in the Medicare Economic Index (MEl) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the clinic during that state fiscal year. The clinic/center must supply a budgeted cost report of the change in service to justify scope of service adjustments.

For newly qualified FQHCs/RHCs after State Fiscal Year 2001, initial payments are established by cost reporting methods. A newly qualified clinic/center shah submit a budgeted cost report from which an interim rate shall be established. After completion of a clinic/center fiscal year, a final PPS rate will be established. After the initial year, payment is set using the MEl methods used by other clinics/centers, with adjustments for increases or decreases in the scope of service furnished by the clinic/center during that fiscal year.

In the case of a FQHC or RHC that contracts with a Medicaid managed care organization, supplemental payments will be made quarterly to the center or clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the center or clinic is entitled under the PPS.

Until a prospective payment methodology is established, the state will reimburse FQHCs/RHCs based on the rate in effect on June 30, 2001. This rate is based on the State Plan in effect on June 30, 2001. The state will reconcile payments made under this methodology to the amounts to which the clinic is entitled under the prospective payment system. This is done by multiplying the encounters during the interim period by the prospective rate and determining the amounts due to (or from) the clinics for the interim period.

XVIII. Outpatient Surgical Centers

The Department shall utilize the 1996 Medicare ambulatory surgical center group rates for the federal Cincinnati, Ohio-Kentucky region to reimburse for an outpatient surgical center service. Following is a chart which states the reimbursement rate for each corresponding surgical group:

| ASC Group | Reimbursement Rate |
|---|---|
| Group 1 | $307.38 |
| Group 2 | $412.79 |
| Group 3 | $471.90 |
| Group 4 | $582.25 |
| Group 5 | $664.02 |
| Group 6 | $775.59 |
| Group 7 | $921.15 |
| Group 8 | $911.55 |

Procedures that are not included in one (1) of the eight (8) Medicare surgical groups, reimbursement shall be on the basis of forty-five (45) percent of the center's usual and customary charge for the procedure performed. Payment rates shall not exceed the provider's usual and customary charge to the general public. Hospital based outpatient surgical centers shall be reimbursed in the same manner as hospital outpatient services.

XIX Nurse-Midwife Services

Participating nurse-midwife providers shall be paid only for covered services rendered to eligible recipients, and services provided shall be within the scope of practice of the nurse-midwife.

For services provided on or after July 1, 1990, payments to nurse-midwives shall be at usual and customary actual billed charges on a procedure-by-procedure basis, with reimbursement for each procedure to be the lesser of the actual billed charge or at seventy—five (75) percent of the fixed upper limit per procedure for physicians.

XX Nurse Anesthetist services

Reimbursement will be made at the rate of seventy—five (75) percent of the anesthesiologist's allowable charge for the same procedure under the same conditions, or at actual billed charges if less.

Exception:

For inpatient delivery—related anesthesia services provided on or after December 1, 1988, a nurse anesthetist will be reimbursed the lesser of the actual billed charge or the standard fixed fee paid by type of procedure. Those procedures and fixed fees are:

| | |
|---|---|
| Normal Delivery | $150.00 |
| Low Cervical C-Section | $202.50 |
| Classic C-Section | $240.00 |
| Epidural Single | $236.25 |
| Epidural Continuous | $251.25 |
| C-Section with Hysterectomy, subtotal | $240.00 |
| C-Section with Hysterectomy, total | $240.00 |
| Extra peritoneal C-Section | $240.00 |

XXI. Podiatry Services

The cabinet shall reimburse licensed, participating podiatrists for covered podiatry services rendered to eligible Medical Assistance recipients at the usual and customary actual billed charge up to the fixed upper limit per procedure established by the cabinet at 65 percent of the median billed charge for outpatient services and 50 percent of the median billed charge for inpatient services using 1989 calendar year billed charges. If there is no median available for a procedure, or the cabinet determines that available data relating to the median for a procedure is unreliable, the cabinet shall set a reasonable fixed upper limit for the procedure consistent with the general array of upper limits for the type of service. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein.

XXII. Hospice Care

A. General Reimbursement

Reimbursement for hospice care will be made at one of four predetermined rates for each day in which a recipient is under the care of the hospice. The daily rate is applicable to the type and intensity of services furnished to the recipient for that day. There are four levels of care into which each day of care is classified:

1. Routine Homecare
2. Continuous Homecare
3. Inpatient Respite Care
4. General Inpatient Care

The Medicaid hospice rates are set prospectively by Centers for Medicare and Medicaid Services, based on the methodology used in setting Medicare hospice rates and adjusted to disregard the cost offsets attributable to Medicare coinsurance amounts. Hospice payment rates are also adjusted for regional differences in wages, using indices published in the Federal Register.

B. Reimbursement for Room and Board

Hospice is reimbursed a per diem amount to cover room and board, for those recipients who reside in a nursing facility. The state shall reimburse ninety five percent (95%) of the nursing facility's Medicaid per diem to the hospice provider, to cover the expenses of the room and board provided to the hospice patient who occupies a Medicaid certified bed in a nursing facility.

The hospice provider shall have a contract with the nursing facility stipulating that:

1. Room and board shall be provided by the nursing facility for the hospice resident;
2. The rate the nursing facility will charge the hospice provider for room and board furnished to the Medicaid hospice resident; and
3. The hospice is fully responsible for the professional management of the Medicaid hospice patient's care.

C. Limitation on Payments for Inpatient Care

1. The total payment to the hospice for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients not exceed twenty percent (20°/c) of the total days for which these patients have elected hospice.

2. At the end of the cap period, Medicaid will calculate a limitation on payment for inpatient care (general or respite) to ensure payment is not made in excess of twenty percent (20%) of the total number of days of hospice care furnished to Medicaid patients.

3. If the number of days of inpatient care furnished to Medicaid patients is equal to or less than twenty percent (20%) of the total days of hospice care to Medicaid patients, no adjustment is necessary. Overall payments to a hospice are subject to the cap amount.

D. Monitoring of Reimbursement

The Department for Medicaid Services will perform a desk audit on each hospice provider once a year following the end of the cap period in order to compute and apply the cap amount and audit payments made for inpatient services.

XXIII. Case Management Services

A. Targeted case management services for adults and children with Substance Use Disorders.

*Monthly Rate:*

Targeted case management for adults and children with substance use disorders will be reimbursed at a monthly rate of $334. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner, consistent with the minimum case manager qualifications for this service, to derive the 15 minute unit base rate of $10.76. This base rate was increased by 12% to account for overhead costs, which creates the 15 minute unit rate of $12.05. Assuming 25 cases per month, the amount of working time per month is estimated to be 6.93 hours per each case. That working time, multiplied by four 15 minute units of the Bachelors-level base rate of $12.05, equals $334 per month. These rates are effective 7/1/2014.

A unit of service shall:
(a) Be one (1) month; and
(b) Consist of a minimum of four (4) service contacts including:
    1. At least two (2) face-to-face contacts with the recipient; and
    2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

B. Targeted case management services for adults and children with Co-occurring Mental Health or Substance Use Disorders and Chronic or Complex Physical Health Issues.

*Monthly Rate:*

Targeted case management for adults and children with co-occurring mental health or substance use disorders and chronic or complex physical health issues will be reimbursed at a monthly rate of $541. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner to derive the 15 minute unit base rate of $10.76. After accounting for the additional education of a Masters-level practitioner (33%) and overhead costs (12%), the 15 minute unit rate is $15.60. Assuming 20 cases per month, the amount of working time per month is estimated to be 8.66 hours per each case. That working time, multiplied by four 15 minute units of $15.60, equals $541 per month. This rate is effective 7/1/2014.

A unit of service shall:
(a) Be one (1) month; and
(b) Consist of a minimum of five (5) service contacts including:
    1. At least three (3) face-to-face contacts with the recipient (may include parent/legal guardian for individuals under age 21); and
    2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

XXIII. Case Management Services

C. Targeted case management services for adults and children with Severe Emotional Disability or Severe Mental Illness

*Monthly Rate:*

Targeted case management for adults and children with severe emotional disability or severe mental illness will be reimbursed at a monthly rate of $334. This rate was established using a reasonable estimate for the salary and fringe benefits of a Bachelors-level practitioner, consistent with the minimum case manager qualifications for this service, to derive the 15 minute unit base rate of $10.76. This base rate was increased by 12% to account for overhead costs, which creates the 15 minute unit rate of $12.05. Assuming 25 cases per month, the amount of working time per month is estimated to be 6.93 hours per each case. That working time, multiplied by four 15 minute units of the Bachelors-level base rate of $12.05, equals $334 per month. These rates are effective 7/1/2014.

A unit of service shall:
(a) Be one (1) month; and
(b) Consist of a minimum of four (4) service contacts including:
    1. At least two (2) face-to-face contacts with the recipient; and
    2. Two (2) additional contacts which may be by telephone or face-to-face with, or on behalf of, the recipient.

XXV. Advanced Registered Nurse Practitioner Services

(1) Reimbursement

a. Participating licensed advanced registered nurse practitioners (ARNP) shall be paid only for covered services rendered to eligible recipients. and services provided shall be within the scope of practice of a licensed ARNP.

b. Except as specified in subsection c of this section or Section 2 below, reimbursement for a procedure provided by an ARNP shall be at the lesser of the following:
   1. The ARNP's actual billed charge for the service; or
   2. Seventy-five (75) percent of the amount reimbursable to a Medicaid participating physician for the same service.

c. An ARNP employed by a primary care center, federally qualified health center, hospital. or comprehensive care center shall not be reimbursed directly for services provide in that setting while operating as an employee.

(2) Reimbursement Limitations.

a. The fee for administration of a vaccine to a Medicaid recipient under the age of twenty-one (21) by an ARNP shall be three (3) dollars and thirty (30) cents up to three (3) administrations per ARNP. per recipient. per date of service.

b. The cost of a vaccine provided to a physician or other provider enrolled in the Vaccines for Children (VFC) Program and available free through the Vaccines for Children Program shall not be reimbursed.

c. For information relating to physician injectable drug products that are administered by a physician or their authorized agent during an in office procedure see Attachment 4.19-B, Page 20.1(b).

d. Reimbursement for an anesthesia service provided during a procedure shall be inclusive of the following elements:
   1. Preoperative and post-operative visits;
   2. Administration of the anesthetic;
   3. Administration of intravenous fluids and blood or blood products incidental to the anesthesia or surgery;
   4. Post-operative pain management: and
   5. Monitoring services.

e. Reimbursement of a psychiatric service provided by an ARNP shall be limited to four (4) psychiatric services per ARNP, per recipient. per twelve (12) months.

f. Reimbursement for a laboratory service provided in an office setting shall be inclusive of:
   1. The fee for collecting and analyzing the specimen; and
   2. Should the test require an arterial puncture or venipuncture, the fee for the puncture.

g. Reimbursement shall be limited to one (1) of the following evaluation and management services performed by an ARNP per recipient. per date of service:
   1. A consultation service:
   2. A critical care service;
   3. An emergency department evaluation and management service:
   4. A home evaluation and management service;
   5. A hospital inpatient evaluation and management service;
   6. A nursing facility service:
   7. An office or other outpatient evaluation and management service:
   8. A preventive medicine service: or
   9. A psychiatric or other psychotherapy service.

XXVI: Federally Qualified Health Center Services

Enrolled Federally Qualified Health Center providers shall be paid full reasonable cost determined in the same manner as for primary care centers except that cost shall not include an incentive payment.

XXVIII. Services Provided by Local Health Departments.

1. Services that are provided by local health departments shall be reimbursed 100% of the Medicare Physician Fee Schedule rate that is in effect as of January 1, 2014 and updated annually on January 1st. The Fee Schedule is located at http://www.chfs.ky.gov/NR/rdonlyres/AAF5A26B-D321-4D41-9AB0-8A49CF4BE3AB/0/Preventive2012FeeSchedule6WEB.pdf. Any codes on the aforementioned Fee Schedule that is not on the Medicare Fee Schedule will be reimbursed at the Medicaid developed Physician Fee Schedule, last updated on January 1, 2013, or Dental Fee Schedule, last updated on January 1, 2009, both of which are located at http://www.chfs.ky.gov/dms/fee.htm

2. Covered services shall be provided by a:

   a. Physician;

   b. Dentist;

   c. Physician Assistant;

   d. Public Health Dental Hygienist;

   e. Advanced Registered Nurse Practitioner; or

   f. Registered Nurse. A "registered nurse" is defined by state law as a person who is licensed in accordance with state law to engage in registered nursing practice. State law defines "registered nursing practice" as the performance of acts requiring substantial specialized knowledge, judgment, and nursing skill based upon the principles of psychological, biological, physical, and social sciences in the application of the nursing process in:

      (1) The care, counsel, and health teaching of the ill, injured, or infirm;
      (2) The maintenance of health or prevention of illness of others;
      (3) The administration of medication and treatment as prescribed by a physician, physician assistant, dentist, or advanced registered nurse practitioner and as further authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses. Components of medication administration include but are not limited to:

         (a) Preparing and giving medications in the prescribed dosage, route, and frequency, including dispensing medications;
         (b) Observing, recording, and reporting desired effects, untoward reactions, and side effects of drug therapy;
         (c) Intervening when emergency care is required as a result of drug therapy;
         (d) Recognizing accepted prescribing limits and reporting deviations to the prescribing individual;
         (e) Recognizing drug incompatibilities and reporting interactions or potential interactions to the prescribing individual; and
         (f) Instructing an individual regarding medications;

(4) The supervision, teaching of, and delegation to other personnel in the performance of activities relating to nursing care; and
(5) The performance of other nursing acts which are authorized or limited by the Kentucky Board of Nursing, and which are consistent either with American Nurses' Association Standards of Practice or with Standards of Practice established by nationally accepted organizations of registered nurses.

3. This methodology applies to the following services:

a. Early and periodic screening, diagnosis, and treatment (EPSDT) services which are described in Attachment 3.1-A, pages 7.1.2 – 7.1.4, 7.1.7, 7.1.8 and Attachment 3.1-B, pages 16-18, 20.1 and 20.2.

b. Pediatric services which include the following:

(1) Diagnostic and nursing evaluation and management services;
(2) Provision of all childhood immunizations as described by Attachment 3.1-A, page 9a included in the Vaccines for Children (VFC) program. Providers will only be reimbursed the administration fee for vaccines provided under the VFC program. Provision of other immunizations to children as recommended by the CDC;
(3) Medications and other treatment procedures; and
(4) Follow-up nursing care.

c. Prenatal and related services – Services provided or arranged in accordance with the standards developed for the prenatal program include the following:

(1) Pregnancy testing/confirmation;
(2) Contact visit counseling;
(3) Initial examination;
(4) Subsequent monitoring visits;
(5) Laboratory tests, as necessary;
(6) Individual counseling;
(7) Hands voluntary home visitation program;
(8) Initial infant assessment;
(9) Postpartum visit; and
(10) Family planning visit.

d. Services for individuals with chronic diseases such as:

(1) Diagnostic evaluation and management services;
(2) Laboratory tests, as necessary;
(3) Medications and other treatment procedures;
(4) Individual counseling; and
(5) Adult immunizations as recommended by the CDC.

e. Chronic disease services which are provided for the following:

(1) Diabetes;
(2) Heart disease and stroke program;
(3) Women's Cancer Screening program;
(4) Substance abuse prevention program;
(5) Tobacco prevention and cessation;
(6) Obesity;
(7) Arthritis/osteoarthritis;
(8) Depression;
(9) Oncology;
(10) Hemophilia;
(11) Sickle Cell;
(12) Organ transplants; and
(13) Rare disease.

f. Family planning services are described in Attachment 3.1-A, page 7.1.9 and Attachment 3.1-B, page 20.3. These services include the following:

(1) Complete medical history;
(2) Physical examination;
(3) Laboratory and clinical test supplies; and
(4) Counseling and prescribed birth control methods to best suit the patient's needs.

XXIX Payments for Non-covered Services Provided Under the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)

When services within the definition of medical services as shown in Section 1905(a) of the Act, but not covered in Kentucky's title XIX state plan, are provided as EPSDT services, the state agency shall pay for the services using the following methodologies:

(1) For services which would be covered under the state plan except for the existence of specified limits (for example, hospital inpatient services), the payment shall be computed in the same manner as for the same type of service which is covered so long as a rate or price for the element of service has been set (for example, a hospital per diem). These services, described as in Section 1905(a) of the Social Security Act, are as follows:

(a) 1905(a)(l), inpatient hospital services;
(b) 1905(a)(2)(A), outpatient hospital services; 1905(a)(2)(B), rural health clinic services; 1905(a)(2)(C), federally qualified health center services;
(c) 1905(a)(3), other laboratory and X-ray services;
(d) 1905(a)(4)(B), early and periodic screening, diagnosis, and treatment services; 1905(a)(4)(C), family planning services and supplies;
(e) 1905(a)(5)(A), physicians services; 1 905(a)(5)(B), medical and surgical services furnished by a dentist;
(f) 1905(a)(6), medical care by other licensed practitioners;
(g) 1905(a)(7), home health care services;
(h) 1905(a)(9), clinic services;
(i) 1905(a)(l0), dental services;
(j) 1905(a)(11), physical therapy and related services;
(k) 1905(a)(12), prescribed drugs, dentures, and prosthetic devices; and eyeglasses;
(I) 1905(a)(13), other diagnostic, screening, preventive and rehabilitative services;
(m) 1905(a)(15), services in an intermediate care facility for the mentally retarded;
(n) 1905(a)(16), inpatient psychiatric hospital services for individuals under age 21;
(o) 1905(a)(1 7), nurse-midwife services;
(p) 1905(a)(18), hospice care;
(q) 1905(a)(19), case management services; and
(r) l905(a)(28), other medical and remedial care specified by the Secretary.

(2) For all other uncovered services as described in Section 1905(a) of the Social Security Act which may be provided to children under age 21, the state shall pay a percentage of usual and customary charges, or a negotiated fee, which is adequate to obtain the service. The percentage of charges or negotiated fee shall not exceed 100 percent of usual and customary charges, and if the item is covered under Medicare, the payment amount shall not exceed the amount that would be paid using the Medicare payment methodology and upper limits. Services subject to payment using this methodology are as follows:

(a) Any service described in one (1), above, for which a rate or price has not been set for the individual item (for example, items of durable medical equipment for which a rate or price has not been set since the item is not covered under Medicaid);
(b) 1905(a)(8), private duty nursing services;
(c) 1905(a)(20), respiratory care services;
(d) 1905(a)(21), services provided by a certified pediatric nurse practitioner or certified family nurse practitioner (to the extent permitted under state law and not otherwise covered under I 905(a)(6); and

3) For medically-necessary evaluative, diagnostic, preventive, and treatment services listed in Section 1905(a) of the Social Security Act, the state shall pay in accordance with items (1) or (3), as applicable, except that for governmental providers the payment shall be a fee-for-service system designed to approximate cost in the aggregate with settlement to reconciled cost. The following describes the methodology utilized in arriving at the rates.

(a) Medicaid providers are paid according to the Kentucky Medicaid Fee Schedule and its modifiers which are maintained by the department and paid through the fee-for-service system. "Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of covered services. The agency's current fee schedule rate was set as of January, 2010 and is effective for services provided on or after that date. All rates are published on the KY Medicaid web site at http://chfs.ky.gov/dms/fee.htm.

(b) Fee for new services are established based on the fees for similar existing services. If there are no similar services the fee is established at 75% of estimated average charge.

(c) Fees for particular services can be increased based on administrative review if it is determined that the service is essential to the health needs of Medicaid recipients, that no alternative treatment is available, and that a fee adjustment is necessary to maintain physician participation at a level adequate to meet the needs of Medicaid recipients. A fee may also be decreased based on administrative review if it is determined that the fee may exceed the Medicare allowable amount for the same or similar services, or if the fee is higher than Medicaid fees for similar services, or if the fee is too high in relation to the skills, time and other resources required to provide the particular service.

(d) Medicaid Services Provided in Schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following as described in Attachment 3.1-A pages 7.1.7(b)-7.1.7(e):

1. Audiology
2. Occupational Therapy
3. Physical Therapy
4. Behavorial Health Services
5. Speech
6. Nursing Services
7. Respiratory Therapy
8. Transportation

The interim payment to the Local Education Agencies for services (Paragraph (d) 1-7) listed above are based on the physician fee schedule methodology as outlined in Kentucky Medicaid Fee Schedule.

(e) Direct Medical Services Payment Methodology

Beginning with cost reporting period August 1, 2008, the Department for Medicaid Services (DMS) will begin using a cost based methodology for all Local Education Agencies (LEAs). This methodology will consist of a cost report, time study and reconciliation. If payments exceed Medicaid-allowable costs, the excess will be recouped.

Once the first year's cost reports are received, and each subsequent year, the Department will examine the cost data for all direct medical services to determine if an interim rate change is justified.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions of the covered Medicaid services delivered by school districts in Attachment 3.1-A pages 7.1.7(b) - 7.1.7(e).

   Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies and equipment.

   Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:

   1) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;

   2) The use of the device must be determined suitable for the individual; and

   3) The service or device must be approved by one of the covered medical professionals and reviewed by the Kentucky Department for Medicaid Services.

   These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of cost and methods of cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct costs for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above.

   A time study which incorporates a CMS-approved methodology is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

4. Net direct costs and indirect costs are combined.

5. Medicaid's portion of total net costs is calculated by multiplying the results from Item 4 by the ratio of the total number of students with Medicaid Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP) receiving services to the total number of students with an IEP or an IFSP.

(f) Transportation Services Payment Methodology

Effective dates of services on or after August 1, 2008, providers will be paid on a interim cost basis. Providers will be reimbursed interim rates for School Based Health Services (SBHS) Specialized Transportation services at the lesser of the provider's billed charges or the interim rate. The interim rate will be a per mile amount determined by the Department of Education Division of School Finance based on data collected from school districts. This interim rate will be an average of each school district's actual cost per mile. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1. Special transportation is specifically listed in the IEP as a required service;
2. A medical service is provided on the day that specialized transportation is provided; and
3. The service billed only represents a one-way trip.

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified on the cost report includes the following:

1. Bus Drivers
2. Mechanics
3. Substitute Drivers
4. Fuel
5. Repairs & Maintenance
6. Rentals
7. Contract Use Cost
8. Vehicle Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and the Department of Education level. The Chart of Accounts is uniform throughout the State of Kentucky. Costs will be reported on an accrual basis.

1. A rate will be established and applied to the total transportation cost of the school district or the Department of Education. This rate will be based on the *Total IEP Special Education Department (SPED) Students in District Receiving Specialized Transportation* divided by the *Total Students in District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Department of Education Transportation Cost* for each of the categories listed above will be include on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP One Way Trips* divided by the total number of *SPED IEP One Way Trips*. This data will be provided from transportation logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.

2. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Kentucky public school districts use predetermined fixed rates for indirect costs. The Department of Education (KDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

3. Net direct costs and indirect costs are combined.

(g) Certification of Funds Process

On an annual basis, each provider will certify through its cost report its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(h) Annual Cost Report Process

For Medicaid services listed in Paragraph (d) 1-8 provided in schools during the state fiscal year, each LEA provider must complete an annual cost report. The cost report is due on or before April 1 following the reporting period.

The primary purposes of the cost report are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.
2. Reconcile annual interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual SBHS Cost Report includes a certification of funds statement to be completed, certifying the provider's actual, incurred costs/expenditures. All filed annual SBHS Cost Reports are subject to desk review by Department for Medicaid Services (DMS) or its designee.

(i) The Cost Reconciliation Process

The cost reconciliation process must be completed by DMS within twenty-four months of the end of the reporting period covered by the annual SBHS Cost Report. The total CMS-approved, Medicaid-allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS), resulting in a cost reconciliation.

For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes. Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(j) The Cost Settlement Process

EXAMPLE: For services delivered for the period covering August 1, 2007, through July 31, 2008, the annual SBHS Cost Report is due on or before April 1, 2009, with the cost reconciliation and settlement processes completed no later than July 31, 2010.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the cost report is submitted. DMS will submit the federal share of the overpayment to CMS within 60 days of identification.

If the actual, certified costs of a LEA provider exceed the interim payments, DMS will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

The Department for Medicaid Services (DMS), Kentucky Department of Education (KDE) and individual schools wish to share in the responsibility for promoting access to health care for students in the public school system, preventing costly or long term health care problems for at risk students, and coordinating students' health care needs with other providers. Many of these activities, when performed by school staff, meet the criteria for Medicaid school-based administrative claiming and may be reimbursable. For this purpose we have produced the Kentucky School Based Time Study document to set out the method for these reimbursements.

State: _____Kentucky_____

XXX. Radiological (X-ray) Services

Payments for radiological services covered pursuant to the mandate contained in 42 CFR 440.30 shall be at usual and customary charges up to sixty (60) percent of the allowable physician fee for the same procedures where the physician is performing both the professional and technical portions of the service.

XXXI. Payment methodology for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, and for children under the supervision of the state, and for adults in need of protective services.

A. Targeted case management services for children in the custody of, or who are at risk of being in the custody of the state.

The payment rate for targeted case management is a negotiated rate between the provider and the subcontractor and approved by the Department for Medicaid Services, based upon the documented cost for the direct provision of the service.

The payment rate for a targeted case management service that is authorized after June 30, 2002, is a uniform rate, determined by 98% of the weighted median of claims for targeted case management services for children in the custody of, or who are at risk of being in the custody of the state, for the period of calendar year 2001.

The billable unit of service is one month

B. Targeted case management services for children under the supervision of the state and for adults in need of protective services.

Payments for targeted case management services for the target populations are monthly. They are based upon one or more documented targeted case management services provided to each client during that month. The monthly rate for the targeted case management services is based on the total average cost per client served by the provider. The monthly rate is established on a prospective basis based upon actual case management costs for the previous year. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year. If a projected interim rate is to be used, it shall be based on the prior year's cost report, if available, or on estimates of the average cost of providing case management services based on financial information submitted by the provider.

Case management providers who are public state agencies shall have on file an approved cost allocation plan. If the state Public Health or Title V agency subcontracts with another state agency for the provision of the services, it shall be the subcontracting state agency's approved cost allocation plan that shall be required to be on file.

The provider shall accumulate the following types of information for submission to Medicaid as justification of costs and worker activities: directly coded worker time; identification, by recipient and worker, of each individual service provided, a showing of all direct costs for case management activities; and a showing of all indirect costs for case management activities appropriately allocated by the agency cost allocation plan on file or by using generally accepted accounting principles if necessary.

XXII. Specialized Children's Services Clinics

Clinic services provided by Specialized Children's Services Clinics will be reimbursed initially at a statewide uniform all-inclusive rate per visit (encounter rate) of $538. This rate is estimated to approximate the average statewide costs of all clinics providing the service. This rate includes the costs of professional services (physician and mental health professional), related costs of providing a sexual abuse exam, and facility costs (overhead). This rate is based on the projected cost of providing the service as submitted to the department by the providers and a consideration of rates paid to providers for similar services.

Providers will submit cost reports annually. Upon receipt of completed cost reports from alt clinics, the department will establish a rate within 90 days using updated cost data.

Payments made under this provision shall not exceed the upper limit of payment as specified in 42 CFR 447.325.

XXIII. Targeted Case Management and Diagnostic, Preventive and Rehabilitative Early Intervention Services for children eligible for the Early Intervention program provided through a Title V agreement.

This payment system is for all providers, including those providing services under the Title V agreement described in Supplement 1 to Attachment 4.16-A, Item #10.

All costs shall be determined based on the methodology outlined in 0MB Circular A-87. Payments for case management, diagnostic, rehabilitative, and preventive early intervention services shall be made in accordance with a fee schedule established by the Title V agency. Interim payments shall be based on the direct cost of providing the service. Payments for overhead and administrative costs associated with providing the service shall be determined with a settlement to cost at the end of the fiscal year. Providers will submit cost reports no later than 180 days after the end of the state fiscal year.

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XXXV Chiropractic Services

A. Definitions

(1) "Resource-based relative value scale (RBRVS) unit" is a value based on Current Procedural Terminology (CPT) codes established by the American Medical Association assigned to the service which takes into consideration the physicians' work, practice expenses, liability insurance, and a geographic factor based on the prices of staffing and other resources required to provide the service in an area relative to national average price.

(2) "Usual and customary charge" refers to the uniform amount the individual physician charges in the majority of cases for a specific medical procedure or service.

(3) "Covered chiropractic services" shall include the following:

(a) An evaluation and management service;
(b) Chiropractic manipulative treatment;
(c) Diagnostic X-rays;
(d) Application of a hot or cold pack to one (1) or more areas;
(e) Application of mechanical traction to one (1) or more areas;
(f) Application of electrical stimulation to one (1) or more areas; and
(g) Application of ultrasound to one (1) or more areas.

B. Reimbursement

(1) Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Chiropractic Services. The agency's fee schedule rate was set as of January 1, 2014, and is effective for services provided on or after that date. All rates are published on DMS's website at http://www.chfs.ky.gov/dms/fee.htm.

(2) If there is no RBRVS based fee the Department shall set a reasonable fixed upper limit for the procedure consistent with the general rate setting methodology. Fixed upper limits not determined in accordance with the principle shown in this section (if any) due to consideration of other factors (such as recipient access) shall be specified herein. RBRVS units shall be multiplied by the Non-anesthesia Related Services dollar conversion factor of $29.67 to arrive at the fixed upper limit.

C. Reimbursement Exceptions.

(1) Payment for individuals eligible for coverage under Medicare Part B is made, in accordance with Sections A and B and items (1) through (4) and (6) of this section within the individual's Medicare deductible and coinsurance liability.

(2) Procedures specified by Medicare and published annually in the Federal Register and which are commonly performed in the chiropractor's office are subject to outpatient limits if provided at alternative sites and shall be paid adjusted rates to take into account the change in usual site of services.

D. Assurances. The state hereby assures that (1) payment for chiropractor services are consistent with efficiency, economy, and quality of care (42 CFR 447.200); and (2) payments for services do not exceed the prevailing charges in the locality for comparable services under comparable circumstances (42 CFR 447.325).

Targeted case management services for at risk parents during the prenatal period and until the child's third birthday

This payment system is for all providers, including those providing services under the Title V agreement described in Attachment 4.16-A, Item #10.

Payments shall be based on cost. Interim rates based on projected cost shall be used with a settlement to cost at the end of the state fiscal year. Case management providers who are public state agencies shall have on file an approved cost allocation plan.

Interim rates shall he established in the following manner:

1) The rate for the assessment shall be based on the projected cost of providing the service consistent with methodology in 0MB Circular A-87. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

2) The rate for the professional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

3) The rate for the family service worker/paraprofessional home visit shall be based on the projected cost of providing the service. This will include a cost based on the average amount of time required to provide the service, and all related costs of providing the service, including collateral contacts, telephone contacts, travel and indirect (overhead) costs.

Cost will be accounted for as follows:

1) Case management staff directly related to the targeted case management program will code all direct time using categories designated for case management functions in 15 minute increments.

2) Any contract costs (i.e., for contracted services) will be based on the actual cost of acquisition of the service.

3) Any indirect costs of any public state agency will be determined using the appropriate cost allocation plan.

Providers will submit cost reports no later than 180 days after the end of the state fiscal year. Interim payments will be adjusted to actual cost based upon review and acceptance of these cost reports in accordance with usual agency procedures.

Reimbursement for Physical, Occupational and Speech Therapy - Outpatient

Reimbursement for physical, occupational, and speech therapy services are based on the Kentucky specific Medicaid fee schedule, which can be found at http://chfs.ky.gov/dms/fee.htm. The Medicaid fee schedule is based on the following methodology:

- Physician Base Fee is calculated based on 75% of the Medicare rate, as published by CMS on an annual basis.

- Other practitioners will be reimbursed based on a step down methodology calculated as a percentage of the physician rate of 75% of the Medicare rate. The step down includes:
  - 85% - Physical Therapist, Occupational Therapist, Speech Language Pathologist
  - 50% - Physical Therapy Assistant working under the supervision of a Physical Therapist if the Physical Therapist is the billing provider for the service, Occupational Therapy Assistant working under the supervision of an Occupational Therapist if the Occupational Therapist is the billing provider,

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: _____Kentucky_____

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Payment of Medicare Part A & Part B Deductible/Coinsurance

A. Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State Plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a specified rate or method is set out on Page 3 in item B of this attachment (see 3.below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR".

3. Payments are up to the amount of a special rate, or according to a special method, described on page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters 'NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on page 3 in item B of this attachment (See 3. Above)

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: _____Kentucky_____

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

| | | | |
|---|---|---|---|
| QMBs: | Part A: | _MR_ Deductibles | _MR_ Coinsurance |
| | Part B: | _MR_ Deductibles | _MR_ Coinsurance |
| Other Medicaid Recipients | Part A: | _MR_ Deductibles | _MR_ Coinsurance |
| | Part B: | _MR_ Deductibles | _MR_ Coinsurance |
| Dual Eligible (QMB Plus) | Part A: | _MR_ Deductibles | _MR_ Coinsurance |
| | Part B: | _MR_ Deductibles | _MR_ Coinsurance |

STATE PLAN UNDER TITLE XIX of the SOCIAL SECURITY ACT
State: _____Kentucky_____

Payment of Medicare Part A and Part B Deductible/Coinsurance (cont.)

B. Medicaid payment for specified Medicare crossover claims will be the lower of the allowed Medicaid payment rates or the Medicare coinsurance and deductibles.

1. The specified Medicare Part A crossover claims are defined as: Inpatient Hospital and Nursing Facilities (effective 9/01/02).

2. The specified Medicare Part B claims are defined as:

a. Physician services, Community Mental Health Center services, Advanced registered nurse practitioner services, podiatry services, chiropractic services, dental services, hearing and vision services, and laboratory and x-ray services (effective 2/01/03);
b. Durable Medical Equipment and Pharmacy (effective 4/01/03);
c. Emergency ambulance services (effective 6/01/03); and
d. Ancillary Services/Nursing Facilities (effective 11/01/03).

In the event that Medicaid does not have a price for codes included on a crossover claim the Medicare coinsurance and deductible will be paid.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed in Intermediate Care Facilities for the Mentally Retarded in accordance with the following:

A. Payment for the bed reservation shall not exceed the following number of days:

A maximum of fifteen (15) days for a hospital stay for treatment of an acute condition(s), and a total of forth-five (45) days for leave(s) of absence in any given quarter (except that not more than thirty (30) days of such leave may be consecutive days).

B. Payment may ordinarily be made when the following conditions exist:

1. The individual is an eligible recipient and is authorized for Program benefits in the level of care in which he is currently residing.

2. The individual is expected to return to the same level of care, barring complications:

3. There is a likelihood that the bed would be occupied by some other patient if not reserved (facilities with a vacancy history would not be reimbursed for reserving a bed);

4. In the case of a leave of absence, the physician orders and the patient's plan of care provides for such an absence.

PAYMENTS FOR RESERVED BEDS

Payment is made for a reserved bed for price-based nursing facilities in accordance with the following:

The program will cover reserved bed days in accordance with the following specified upper limits and criteria.

(1) Reserved bed days will be covered for a maximum of fourteen (14) days per calendar year due to hospitalization.

(2) Reserved bed days will be covered for a maximum of ten (10) days during the calendar years for leaves of absence other than for hospitalization.

(3) Reserved bed days will be reimbursed at seventy-five (75) percent of a facility's rate if the facility's occupancy percent is ninety-five (95) percent.

(4) Reserved bed days will be reimbursed at fifty (50) percent of a facility's rate if the facility's occupancy percent is less than ninety-five (95) percent.

(5) Coverage during a recipient's absence for hospitalization or leave of absence is contingent on the following conditions being met:

(a) The person is in Title XIX payment status in the level of care he/she is authorized to receive and has been a resident of the facility at least overnight. Persons for whom Title XIX is making Title XVIII co-insurance payments are not considered to be in Title XIX payment status for purposes of this policy;

(b) The person can be reasonably expected to return to the same level of care;

(c) Due to demand at the facility for beds at that level, there is a likelihood that the bed would be occupied by some other patient where it not reserved;

(d) The hospitalization is for treatment of an acute condition, and not for testing, brace-fitting, etc.: and

(e) In the case of leaves of absence other than for hospitalization, the patient's physician orders and plan of care provide for such leaves. Leaves of absence include visits with relatives and friends, and leaves to participate in state-approved therapeutic or rehabilitative programs.

FACILITY REIMBURSEMENT – METHODS AND PROCEDURES
FOR JANUARY 1, 2000 AND THEREAFTER

The following sections summarize the cost-based and price-based reimbursement methodologies for facilities in Kentucky.

Participation Requirements

To participate in the Medicaid Program, the facilities are required to be licensed as nursing facilities or as an intermediate care facility for individuals with an intellectual disability. Hospitals provide swing-bed hospital nursing facility care shall not be required to have the hospital beds licensed as NF beds. All nursing facilities (NFs) must participate in Medicare in order to participate in Medicaid, except for those NFs with waivers of the nursing requirements (who are prohibited by statute from participation in Medicare).

Audits

The state agency reviews all cost reports for compliance with administrative thresholds. Costs will be limited to those cost found reasonable. Overpayments found in audits under this paragraph will be accounted for in accordance with federal regulations.

Cost-Based Facilities

The following facilities shall be included in the cost-based facility methodology:

a. A nursing facility with a certified brain injury unit;

b. A nursing facility with a distinct part ventilator unit;

c. A nursing facility designed as an institution for mental disease;

d. A dually-licensed pediatric nursing facility;

e. An intermediate care facility for individuals with an intellectual disability;

f. Veteran's Affairs (VA) state operated and controlled nursing facility.

Cost Reports for Cost-Based Facilities

With the exception of the VA nursing homes, facilities shall use a uniform cost reporting form for submission at the facility's fiscal year end. The single state agency shall set a uniform rate year for cost-based NF's and ICF-IIDs (July 1-June 30) by taking the latest available cost data which is available as of May 16 of each year and trending the facility costs to July 1 of the rate year. For the VA facilities, the Medicare 2540-10 will be the cost report version used.

1. If the latest available cost report period has not been audited or desk reviewed prior to rate setting, the prospective rates shall be based on cost reports which are not audited or desk reviewed subject to adjustment when the audit or desk review is completed. If desk reviews or audits are completed after May 16, but prior to universal rate setting for the next rate year, the desk review or audited data shall be used.

2. Partial year or budgeted cost data may be used if a full year's data is unavailable. Unaudited reports shall be subject to adjustment to the audited amount.

3. Facilities paid on the basis of partial year or budgeted cost reports shall have their reimbursement settled back to allowable cost.

Allowable Cost

Allowable costs are cost found necessary and reasonable by the single state agency using Medicare Title XVIII-A principles except as otherwise stated in the approved state plan. Bad debts, charity and courtesy allowances for non-Title XIX patients are not included in allowable costs. A return on equity is not allowed.

Methods and standards for Determining Reasonable Cost-Related Payments

The methods and standards for the determination of reimbursement rates to non-Veteran's Affairs nursing facilities and intermediate care facilities for individuals with intellectual disabilities is as described in the Nursing Facility Reimbursement manual which is Attachment 4.19-D, Exhibit B. For VA facilities, the interim rates will be based on a pro-forma cost report until their first full year Medicare cost report is submitted. Thereafter, interim rates will be based on the per diem cost substantiated by the most recently available cost report data.

Payments Rates resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The rates take into account economic trends and conditions since costs are trended to the beginning of the rate year (July 1) and then indexed for inflation for the rate year using Global Insight inflation index.

3. Interim rates are established on July 1 of each year. Interim rates will be adjusted to include the cost of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting resident patient care, to correct errors in the rates (whether due to action or inaction of the state or the facilities), or to address displacement of residents. Rates shall be adjusted to an audited cost base if an unaudited cost report has been used due to new construction or other specified reasons which requires using an unaudited cost report.

4. The Medicare Upper Payment Limit (UPL) described in Exhibit B, Section 705 of this attachment is subject to increase to take into account any costs incurred to comply with Federal requirements or a combination of Federal and State requirements that were not in effect during the Medicare UPL base year. These requirements are actions that increase costs as a result of staffing ratio increases, level of service increases, to accommodate changes of circumstances affecting patient care, or to address displacement of residents. 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 in Exhibit B, Section 705.

a. NF/Brain Injury Units means units recognized by the Medicaid agency as specially designated and identified NF units dedicated to, and capable of, provide care to individuals with severe head injury. Facilities providing preauthorized specialized rehabilitation services for persons with brain injuries with rehabilitation complicated by neurobehavioral sequelae means a facility appropriately accredited by a nationally recognized accrediting agency or organization. To participate in Kentucky Medicaid the facility or unit must be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

The all-inclusive rate for brain injury unit is $360 per diem, excluding drugs and physician cost. These claims are to be submitted through the pharmacy and physician's programs. For those residents with brain injury and neurobehaviorial sequelae, the per diem is a negotiated rate not to exceed usual and customary charges. This rate excludes drugs and physician costs. These claims shall be submitted through the pharmacy and physician's programs.

b. Certified distinct part ventilator nursing facility unit means a preauthorized distinct part unit of not less than twenty (20) beds with a requirement that the facility have a ventilator patient census of at least fifteen (15) patients. The patient census shall be based upon the quarter preceding the beginning of the rate year, or upon the quarter precedent the quarter for which certification is requested if the facility did not qualify for participation as a ventilator care unit at the beginning of the rate year. The unit must have a ventilator machine owned by the facility for each certified bed with an additional backup ventilator machine required for every tent (10) beds. The facility must have an appropriate program for discharge planning and weaning from the ventilator. The fixed rate for hospital based facilities is $460.00 per day, and the fixed rate for freestanding facilities is $250.00 per day. The rates are to be increased based on the Data Resources Incorporated inflation index for the nursing facility services for each rate year beginning with the July 1, 1997 rate year.

5. The following special classes of nursing facilities are addressed in the Medicaid cost-based methodology regulation and are reimbursed at full reasonable and allowable cost in accordance with methodology described in Attachment 4.19 D, Exhibit B:

   a. NF/institutions for Mental Diseases (IMD) means facilities identified by the Medicaid agency as providing nursing facility care primarily to the mentally ill.

   b. NF/Dually licensed pediatric nursing facilities means facilities identified by the Medicaid agency as providing nursing facility care to residents under the age of twenty-one (21).

   c. ICF-IID-Intermediate Care Facilities for individuals with an intellectual disability means facilities identified by the Medicaid agency as providing care primarily to the mentally retarded and developmentally disabled.

   d. Veteran's Affairs nursing facilities.

6. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

7. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

8. Participation in the program is limited to providers of service who accept, as payments in full, the amounts paid in accordance with the State Plan.

9. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19 B, Supplement 1.

Price-Based Nursing Facilities

The following facilities are reimbursed by the price-based nursing facility methodology:

a. A free-standing nursing facility;

b. A hospital-based nursing facility;

c. A nursing facility with waiver;

d. A nursing facility with mental retardation specialty; and

e. A hospital providing swing bed nursing facility care.

Costs Reports for Price-Based Nursing Facilities

Price-based nursing facilities must submit the latest Medicare cost report and the Medicaid supplement schedules attached to Attachment 4.19-0 Exhibit-B. The Medicaid Supplement Schedules are utilized for statistical data. The Medicare Supplemental Cost Schedules are utilized for historical data.

The Medicare cost report and Medicaid supplement schedules shall be submitted to the Department pursuant to time frames established in HCFA Provider Reimbursement Manual-Part 2 (PUB. 15-11) Section 102, 102.1, 102.3 and 104.

Methods and Standards for Determining Price-based Nursing Facility Payments

The methods and standards for the determination of reimbursement rates to price-based nursing facilities is described in the Nursing Facility Reimbursement manual which Is ATTACHMENT 4.19-D, Exhibit B.

Payment Rates Resulting from Methods and Standards

1. Kentucky has determined that the payment rates resulting from these methods and standards are at least equal to the level which the state reasonably expects to be adequate to reimburse the actual allowable costs of a facility that is economically and efficiently operated.

2. The standard price is market-based using historical data, salary surveys and staffing ratios. The standard price accounts for the higher wage rates for the urban area and the slightly lower rates for wages In the rural area.

3. The rate also takes into account a facility specific capital cost component based on an appraisal of each facility and the department shall appraise a price-based Nursing Facility to determine the facility specific capital component again in 2009.

4. The standard price be re-based in 2008 and consists of two components: the "case-mix" adjustable portion and the "non-casemix" adjustable portion.

   (1) The "case-mix" adjustable portion consists of wages for direct care personnel, cost associated with direct care, and non-personnel operation cost (supplies, etc.).

(2) The "non-case mix" adjustment portion consists of all other facility cost except capital cost.

6. Case-mix is based on data extracted from the Minimum Data Set 2.0 submitted to the state survey agency as required by CMS and the individual facility case-mix is calculated using the Resource Utilization Group (RUG) III version 5.12.

7. Rates are established prospectively on July 1 of each year and adjusted for "case-mix at the beginning of each quarter during the rate year (January, April, July, and October). A "case-mix" adjustment is the only adjustment made to the rates by the Department.

8. Other adjustments will not be made to the rates except for errors identified by the Department when computing the rate.

9. Facilities protection period shall be in effect until June 30, 2002. No price-based nursing facility will receive a rate under the new methodology that is less than their rate that was set on July1, 1999, adjustment for the facility's "resident acuity". However, nursing facilities may receive increase in rates as a result of the new methodology as the Medicaid budget allows.

10. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

11. Payments under this methodology must not exceed $260,997,283 for the period of January 1, 2000 to June 30, 2000.

12. The Department remains at risk for increases in total nursing facility payments that result from higher utilization of beds by Medicaid recipients. The Department reserves the right to adjust rates, to remain within budgeted amount.

13. Payments made in accordance with methods and standards described in this attachment are designed to enlist participation of a sufficient number of providers of services in the program. A sufficient number of providers assures eligible persons can receive the medical care and services included in the State Plan at least to the extent these are available to the general public.

14. The Department shall require the submission of the most recent Medicare cost report and the Medicaid Supplemental Schedules included in the manual to be used for historical data.

15. Participation in the program shall be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the State Plan.

16. The state will pay each provider of nursing care services, who furnishes the services in accordance with the requirements of the State Plan, the amount determined for services furnished by the provider under the Plan according to the methods and standards set forth in this attachment.

17. Payments will be made by Medicaid for Medicare Part A and Part B coinsurance in accordance with Attachment 4.19-B, Supplement 1.

PUBLIC PROCESS FOR DETERMINING RATES FOR LONG-TERM CARE FACILITIES

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

Beginning April 2, 2001 and ending June 30, 2005, subject to the availability of funds, the Department will make supplemental payments to qualifying nursing facilities on a quarterly basis. The Department will use the following methodology to determine these payments:

1) For each state fiscal year, the Department will calculate the maximum addition payments that it can make to non-state government-owned or operated nursing facilities as set forth at 42 CFR Section 447.272 (a)(2) and 42 CFR Section 447.272 (b).

2) The Department will use the latest cost report data on file with the Department as of December 31, 2000 to identify the nursing facilities eligible for supplemental payments. To be eligible for supplemental payments the nursing facility must:

   a) Be a nursing facility owned or operated by a local unit of government;
   b) Have at least 140 or more Medicaid certified beds; and
   c) Have Medicaid occupancy at or above 75%.

   A qualifying nursing facility is an eligible facility that is owned or operated by a local unit of government that has entered into an Intergovernmental Transfer Agreement with the Commonwealth.

3) The Department will determine the amount of supplemental payments it will make to qualifying nursing facilities in a manner not to exceed the upper limit amount as calculated in 1 above.

4) Using the cost report data on file as of December 31, 2000, the Department will identify the total Medicaid days reported by the qualifying nursing facilities as identified in 2 above.

5) The Department will divide the total Medicaid days for each qualifying county-owned or operated nursing facility as determined in 2 above by the total Medicaid days for all qualifying facilities to determine the payment supplementation factor.

6) The Department will apply each qualifying county-owned or operated nursing facility's payment supplementation factor determined in 5 above to the total supplemental payment amount identified in 3 above to determine the payment to be made to each qualifying nursing facility.

Effective for services provided on and after September I, 200 I, the Department will make pediatric supplemental payments on a quarterly basis to qualifying nursing facilities. The Department will use the following methodology to determine these payments:

1. For the period of 9/0 1101 through 6/30/02 and annually thereafter (7/01 through 6/30), the Department shall establish a pool of $550,000 to be distributed to qualified facilities based upon their pro rata share of Medicaid patient days.

2. A nursing facility qualifies for a pediatric supplemental payment if it meets the following criteria:

   a. Is located within the Commonwealth of Kentucky;
   b. Has a Medicaid occupancy at or above 85%;
   c. Provides services only to children under age twenty-one (21); and
   d. Has forty (40) or more licensed beds.

Reimbursement for SFY 2002- 2003

A. Excluding nursing facilities with brain injury units, intermediate care facilities for the mentally retarded and developmentally disabled, and state-owned nursing facilities, rates for cost-based nursing facilities will be the rates in effect on June 30, 2002.

B. Rates for price-based nursing facilities will be established in accordance with the methodology described in Attachment 4.19-D, Exhibit A.

KENTUCKY CASE MIX ASSESSMENT AND REIMBURSEMENT SYSTEM

RESIDENT ASSESSMENT

INTRODUCTION

The Kentucky Department for Medicaid Services is implementing a new reimbursement system for price-based nursing facilities participating in the Medicaid program. These facilities include:

1. A free-standing nursing facility;
2. A hospital-based nursing facility;
3. A nursing facility with waiver;
4. A nursing facility with mental retardation specialty; and
5. A hospital providing swing bed nursing facility care.

The new price-based reimbursement methodology will consist of a reasonable standard price set for a day of service for rural and urban facilities. This should provide an incentive to providers to manage costs efficiently and economically.

The standard price includes:

1. Standardized wage rates;
2. Staffing *ratios;*
3. Benefits and absenteeism factors; and
4. "Other cost" percentages.

The new price-based reimbursement methodology is dependent on the specific care needs of each Medicaid and dually eligible Medicare resident in a nursing facility. The new methodology will base the resident acuity using the Minimum Data Set (MDS) 2.0 as the assessment tool. The Resource Utilization Group (RUGs) is the classification tool to place resident into different case-mix groups necessary to calculate the "casemix score", This methodology is based on a snapshot of facility's acuity on a particular point in time.

This methodology entails a re-determination of a facility's mix of residents each quarter in order to establish a new facility specific nursing rate on a quarterly basis.

One of the objectives of the new case-mix system is to mirror the resident assessment process used by Medicare and therefore not require the facilities to use two case-mix assessment tools to determine resident acuity. The second objective for using the MDS 2.0 and RUGS Ill is to improve reimbursement for facilities providing services for residents with higher care needs in order to improve access to care for those recipients.

1. There will be two major categories for the standard price:

   a. Case-mix adjustable portion includes wages for personnel that provide or are associated with direct care and non- personnel operation costs (supplies, etc). The case-mix adjustable portion will be separated into urban and rural designations based on Metropolitan Statistical Area definitions; and

   b. Non case-mix adjustable portion of the standard price includes an allowance to offset provider assessment, food, non-capital facility related cost, professional supports and consultation, and administration. These costs are reflected on a per diem basis and will be based on Metropolitan Statistical Area definitions.

      Effective July 1, 2004, rates are increased $7.60 per day.

2. Each July 1 the rate will be increased by an inflation allowance using the appropriate Data Resource Incorporated (DRI) Index for inflation. The DRI will not be applied to the capital cost component.

4. Capital Cost Add-on:

Each nursing facility will be appraised by November 30, 1999 and the department shall appraise a price-based NF to determine the facility specific capital component again in 2009. The appraisal contractor will use the E. H. Boeckh Co. Evaluation System for facility depreciated replacement cost. The capital cost component add-on will consist of the following limits:

a. Forty thousand dollars per licensed bed;
b. Two thousand dollars per bed for equipment;
c. Ten percent of depreciated replacement cost for land value;
d. A rate of return will be applied, equal to the 20 year Treasury bond plus a 2% risk factor, subject to a 9% floor and 12% ceiling; and
e. In order to determine the facility-specific per diem capital reimbursement, the department shall use the greater of actual bed days or bed days at 90%.

5. Renovations to nursing facilities in non-appraisal years:

a. For facilities that have 60 or fewer beds, re-appraisals shall be conducted if the total renovation cost is $75,000 or more.
b. For facilities that have more than 60 beds, re-appraisal shall be conducted if the total renovation cost is $150,000.

6. Facilities Protection Period:

a. Rate Protection — Until July 1, 2002, no NF shall receive a rate under the new methodology that is less than their rate that was set in July *1,* 1999 unless a facility's residerit acuity changes. However, NFs may receive increases in rates as a result of the new methodology as the Medicaid budget allows.

b. Case Mix — Until July 1, 2000, no facility will receive an average case-mix weight lower than the case-mix weight used for the January 1, 1999 rate setting. After July 1, 2C00 the facility shall receive the case-mix weight as calculated by RUGs Ill from data extracted from MDS 2.0 information.

c. Effective January 1, 2003, county owned hospital-based nursing facilities shall not receive a rate that is less than the rate that was in effect on June 30, 2002.

7. Case-mix Rate Adjustments. Rates will be recomputed quarterly based on revisions in the case mix assessment classification that affects the Nursing Services components.

8. Case-mix rate adjustment will be recomputed should a provider or the department find an error.

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SECTION 100. INTRODUCTION TO PRICE- BASED REIMBURSEMENT SYSTEM

A. January 1, 2000, a price-based reimbursement system will be implemented to reimburse a nursing facility (NF), a nursing facility with waiver (NF-W), a hospital based nursing facility (NF-HB) and a nursing facility with a mental retardation specialty (N F-MRS Beginning).

B. The price-based system is a reimbursement methodology based on a standard price set for a day of service as opposed to reimbursing facilities based on the latest submitted cost report. The standard price is based on reasonable, standardized wage rates, staffing ratios, benefits and absenteeism factors and 'other cost" percentages.

C. A rate model was developed which resolves issues inherent in the current system reflects current reimbursement methodology trends and satisfies the needs of the Department and the Provider community. The goal of the price-based methodology was to develop a uniform, acuity adjustment rate structure that would pay a nursing facility the same reimbursement for the same type of resident served. This rate structure accounts for resource utilization and allows rates to increase annually by an appropriate inflationary factor. The rate model is market based and accounts for the higher wage rates urban facilities must pay their employees; therefore the urban average rate is slightly higher than the rural. The rate does not distinguish between hospital based and freestanding facilities.

D. This payment method is designed to achieve three major objectives:

1. To assure that needed nursing facility care is available for all eligible recipients including those with higher care needs; and,
2. To provide an equitable basis for both urban and rural facilities to participate in the Program; and,
3. To assure Program control and cost containment consistent with the public interest and the required level of care.

E. The system is designed to provide a reasonable reimbursement for providers serving the same type of residents in the nursing facility and to provide for a reasonable rate of return on the provider's investment.

F. The price-based model reimbursement methodology provides for a facility specific capital cost add-on calculated using the E.H. Boeckh System, a commercial valuation system that estimates the depreciated and non-depreciated replacement cost of a facility.

G. The Office of Inspector General has required the submission of the Minimum Data Set (MDS) since 1992 and DMS sought to use a tool familiar to the nursing facility industry in order to calculate case-mix. The case-mix portion of the rate will utilize the MDS 2.0 and the Resource Utilization Group (RUG) Ill to calculate the individual facility's average case-mix.

H. The case-mix portion of the rate will be adjusted quarterly to reflect the facility's most recent case-mix assessment and to adjust the direct care and non-personnel operation costs (supplies, etc.) portion of the standard price for the current quarter.

SECTION 110. PARTICIPATION REQUIREMENTS

A. The facilities referenced in Section one hundred (100) shall be reimbursed using the methodology described in 907 KAR 1:065. These facilities shall be licensed by the state survey agency (Office of Inspector General) for the Commonwealth of Kentucky and certified for Medicaid participation by the Department for Medicaid Services.

B. A nursing facility, except a nursing facility with waiver, choosing to participate in the Medicaid Program will be required to have twenty (20) percent of its Medicaid certified beds participate in the Medicare program or ten (10) of its Medicaid beds participating in the Medicare program whichever is greater. If the NF has less than ten (10) beds all of its beds shall participate in the Medicare Program.

C. The Medicaid Program shall reimburse all Medicaid beds in a nursing facility at the same rate. The Medicaid rate established for a facility is the average rate for all Medicaid participating beds in that individual facility.

SECTION 120. PAYMENTS FOR SERVICES TO MEDICAREIMEDICAID 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 130. PRICE-BASED NF REIMBURSEMENT METHODOLOGY

A. The price-based nursing facility reimbursement methodology reflects the differential in wages, property values and cost of doing business in rural and urban designated areas This results in two standard rates, a standard rate reflecting the lower wages for the rural facilities and a slightly higher rate for the urban facilities.

B. The rural and urban designated areas are based on the “Metropolitan Statistical Area (MSA) designating the urban population centers based on the national census and updated on a yearly basis, as published by the Federal Office of Management and Budget.

C. In order to determine the standard rates for urban and rural facilities, the department utilized an analysis of fair-market pricing and historical cost for staffing ratios, wage rates, cost of administration, food, professional support, consultation, and non-personnel operating expenses as a percentage of total cost.

D. The standard price is comprised of the following components and percentages of the total rate:

1. Personnel 65%

2. Non-personnel operating 6%;
3. Administration 13%;
4. Food 4%;
5. Professional supports & consultation 2%;
6. Non-capital facility related cost 3%; and
7. Capital rate 7%.

E. The standard price shall be re-based in 2008 and adjusted for inflation every July 1.

F. A portion of the standard price for both urban and rural facilities Will be adjusted each calendar quarter for "case-mix". The "case-mix" adjusted portion shall include the following:

1. The personnel cost of a:

(a) DON-Director of Nursing;
(b) RN-Registered Nurse;
(c) LPN-Licensed Practical Nurse;
(d) Nurse Aide;
(e) Activities worker; and
(f) Medical records director.

2. The non-personnel operating cost including:

(a) Medical supplies; and
(b) Activity supplies.

G. The "non-case-mix" portion of the standard price shall not be adjusted for case mix and includes:

1. Administration;
2. Non-direct care personnel;
3. Food;
4. Non-capital related costs;
5. Professional support;
6. Consultation;
7. Capital cost component; and
8. An allowance to offset a provider assessment.

H. The capital cost component shall be an "add-on" to the non case-mix" adjusted portion of the rate.

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

1. Speech Therapy;
2. Occupational Therapy;
3. Physical Therapy;
4. Oxygen Services;
5. Laboratory; and
6. X-ray.

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

K. 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 who 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 (100) 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 reimbursement 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 $22917. 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.

NOTE: Drugs for residents in nursing facilities shall be reimbursed through the pharmacy program.

L. The department shall adjust the Standard Price if:

1. A government entity imposes a mandatory minimum wage or staffing ratio increase and the increase was not included in the DRI; or

2. A new licensure requirement or new interpretation of an existing requirement by the state survey agency that results in changes that: affect all facilities within the class. The provider shall document

that a cost increase occurred as a result of licensure requirement or policy interpretation.

3. The provider- shall submit any documentation required by the department.

SECTION 140. PRICE- BASED NF REIMBURSEMENT CALCULATION

A. For each calendar quarter, based on the classification of urban and rural, the department shall calculate an individual NF's price-based rate to be the sum of:

1. The case-mix adjustable portion of a NF Standard Price, adjusted by the individual NF's current average case-mix index. Except that until June 30, 2000 the average case-mix index shall be the greater of the current average case-mix index or the case-mix average calculated as a ratio of the facility's case-mix index to the statewide average case-mix index that would have been used for January 1, 2000 rate setting. After July 1, 2000 the individual NF's actual average case-mix shall be used in the rate calculation; and

2. The non-case-mix adjustable portion of the assigned total Standard Price and the capital cost component.

B. A capital cost component shall be calculated on an individual facility basis based on the facility appraisal completed in November 1999. Reappraisal shall be conducted and utilized to determine the facility specific capital component. The department shall appraise a price- based NF to determine the facility specific capital component again in 2009. The Department shall contract with a certified appraisal company to perform the appraisal using the E.H. Boeckh Valuation System. The appraisal is based on the depreciated replacement value of the individual facility. The same Appraisal Company shall perform any re-appraisal that may be requested by a facility within that five-year period.

C. A facility may request a re-appraisal within five years should renovations or additions have a minimum total cost of $150,000 for facilities with more than sixty (60) licensed beds. For facilities having sixty (60) or less licensed beds, the total renovation or addition must be a

minimum total cost of $75,000. The individual NF shall submit written proof of construction cost to the department in order to request a reappraisal. The individual NF shall reimburse the department's contracted appraisal company for the cost of the appraisal. The department shall reimburse the facility the cost of the appraisal or re-appraisal upon receipt of a valid copy of the paid invoice from the Appraisal Company.

D. A capital cost component shall be calculated on an individual facility basis. A capital cost component based on the results of the appraisal shall be the total of the average licensed bed value and ten (10) percent of the licensed bed value for land on which the NF is built. To this sum, add two thousand dollars per licensed bed for equipment To determine the rate of return foc capital cost, multiply the sum of the preceding paragraph by the yield on a twenty (20) year Treasury bond plus a risk factor of two (2) percent. The rate of return shall be no less than nine (9) percent or greater than twelve (12) percent per state fiscal year. The final calculation to determine the individual NF's capital cost component shall be the product of the rate of return calculation divided by the total number of NF bed days as calculated in paragraph F of this section.

E. To determine the average licensed bed value, the depreciated replacement cost of the NF shall be divided by the total number of licensed beds in the NF with the following limitations:

1. The average bed value shall not exceed $40,000; and
2. Shall exclude:

   (a) Equipment; and
   (b) Land,

F. NF bed days used in the capital cost rate calculation shall be based on actual bed occupancy, except that the occupancy rate shall not be less than ninety (90) percent of certified bed days.

G. The department shall utilize a rate of return for capital costs that shall be equal to the yield on a twenty (20) year Treasury bond as of the first business day on or after May 31 of each year. Should a change of ownership occur pursuant to 42 CFR 447.253 (2)(d), the new owner shall continue to receive the capital

cost rate of the previous owner unless the NF is eligible for re-appraisal pursuant to section IV B of this manual.

SECTION 150. ON-SITE REVIEWS AND VALIDATION

A. On a quarterly basis, beginning January 1, 2000 the department shall perform an on-site review of the NF. The review will consist of a minimum often (10) percent of the MDS assessments completed by the NF. The department shall validate the MDS assessments by using the Long Term Care Facility Resident Assessment Instrument User's Manual.

B. Should the department invalidate a NF's MDS, the NF may appeal the findings of the department within seven (7) business days. The department shall receive a written request by the NF that the department reconsider the invalidation. The department shall conduct the second validation with seven (7) business days of receipt of the request and notify the provider in writing of the decision. A provider may appeal the second validation per 907 KAR 1:671, Sections 8 and 9.

SECTION 160. 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 and 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 483.1 0(c)(8)(ii).

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 or 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 (1 4th1) 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 170. REIMBURSEMENT FOR REQUIRED SERVICES UNDER TEE PRE-ADMISSION SCREENING RESIDENT REVIEW (PASRR).

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

B. The department shall reimburse a NF for services delivered to an individual if the NF complies with the requirements of 907 KAR 1:755.

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

SECTION 180. NF PROTECTION PERIOD AND BUDGET CONSTRAINTS

A. For the period of January 1, 2000 through June 30, 2002, a NF shall not receive a rate that is less than the rate that s set for the NF pursuant to 907 KAR 1:025E on July 1, 1999, including any capital cost and extenuating circumstances add-ons.

B. The department shall monitor payments on a monthly basis to ensure that aggregate payments made to NF's do not exceed the appropriated funds in fiscal years 2000 through 2002.

C. In order to monitor the payments, the department shall on a monthly basis notify the industry's representatives in writing the total payment amount for the preceding month.

D. The department shall also place on the Medicaid Internet site the amount of payment in aggregate to the NF's for the preceding month and the cumulative amount paid for the current state fiscal year.

SECTION 190. ANCILLARY SERVICES

A. The department shall reimburse for an ancillary service that meets the criteria established in 907 KAR 1:023 utilizing the corresponding outpatient procedure code rate listed in the Medicaid Physicians Resource Based Relative Value Scale fee schedule.

B. The department shall reimburse for an oxygen therapy utilizing the durable medical equipment fee schedule.

C. Respiratory therapy and respiratory therapy supplies shall be considered in the routine services per diem rate.

D. The department shall calculate an add-on amount in accordance with 907 KAR 1:065, Section 12, to be in effect from November 1, 2003 through June 30, 2004, to a nursing facility's routine services per diem rate if the nursing facility incurred cost providing respiratory therapy or respiratory therapy supplies for the period July 1, 2003 through September 30, 2003.

E. A nursing facility shall submit documentation requested by the department in order to apply for a routine services per diem add-on in accordance with 907 KAR 1:065, Section 12.

SECTION 200. REIMBURSEMENT REVIEW AND APPEAL

A NF may Appeal department decisions as to the application of this regulation as it impacts the NF's price-based reimbursement rate in accordance with 907 KAR 1:671, Section 8 and 9.

SECTION 210. COST REPORT INSTRUCTIONS FOR PRICE-BASED

All Medicaid Supplemental Schedules must be accompanied by a working trial balance and audited financial statements (if applicable).

SECTION 1. SCHEDULE NF-1 - PROVIDER INFORMATION

Enter in the appropriate information. Choose whether the cost report is in a leap year or a regular 365 day year. Note that the cost report must have an original signature by an officer or administrator of the facility.

SECTION 2. SCHEDULE NF-2 -- WAGE AND SALARY INFORMATION

This schedule records a facility's labor costs.

A. The pay period starting date should be the first day of the first payroll period in the provider's fiscal year. Likewise, the end date shall be the final day of the last payroll period in the fiscal year.

B. Under wage information, the hours paid includes vacation pay, sick leave, bereavement, shift differential and holidays in *addition to* time engaged in for regular business activity. Hours worked, in contrast, are only those hours that the employee spent at the facility in normal work duties. Wages paid should include all compensation paid to the employee, including time worked, time in training, vacation, and sick time.

C. Expenses incurred with outside businesses for temporary-nursing staff should be placed under contracted services. For each nursing category, enter the hours worked by the contract employees and the amount charged by the contracting business for wages paid. Hours paid and hours worked will differ only if the contract staff engaged in training while being employed at the facility.

D. Benefits paid by the facility for *all employees* (nursing staff, administrative, etc.) should be included under Section C: the facility's contribution for health insurance, life insurance, etc. would be listed under these categories.

SECTION 3. SCHEDULE NF- 3- STAFF INFORMATION

On an annual basis the Department for Medicaid Services shall select a seven-day period in which the facility records information regarding their staffing levels and patient days.

A. Record the number of residents in your facility in the Resident Census section. This includes only those full-time residents in the certified nursing facility section.

B. For each of the staff categories, record the number of staff on duty. Contract staff should be included in this category.

C. Continue this throughout the seven-day survey period.

SECTION 4. SCHEDULE NF- 7— ALLOCATION STATISTICS

A. Section A - Ancillary Charges

1. Column 1. Enter the total charges for each type of ancillary service on Line I through 6. The sum of lines 1 through 6 are totaled on line 7.
2. Column 2. Enter the total charges for each type of ancillary service provided to KMAP patients in certified beds on lines 1 through 6. Lines 1 through 6 a summed and totaled on line 7.
3. Column 3. The Medicaid percentage in column 3 is calculated by dividing KMAP charges in column 2 by total charges in column 1. Percentages shall be carried to four decimal places (i.e., XX.XXXX%).

B. Section B - Occupancy Statistics.

Certified Nursing Facility. Use the Bed Days Available worksheet on Box C to complete lines 1, 2, and 3. For line 4, enter in the Total Patient Days provided to all certified nursing facility residents. On line 6, enter in the KMAP Patient Days.

C. Non-Certified and Other Long-Term Care

1. Lines 1 and 2. Enter the number of licensed beds at the beginning and end of the fiscal year. 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 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, use actual bed days.

3. Line 4. Total patient days should be entered in.

SECTION 5. SCHEDULE NF- 8- MISCELLANEOUS INFORMATION

All providers must complete section A and B.

A. A NF shall submit a Medicare cost report and Medicaid supplement schedule pursuant to HCFA Provider Reimbursement Manual - Part 2 (Pub. 15-11) Section 102, 102.1, 102.3 and 104 included in this manual.

B. A copy of a NF's Medicare cost report for the most recent fiscal year end.

C. A completed copy of the Medicaid supplemental schedules included in this manual shall also be submitted with the NE's Medicare cost report.

D. A cost reports financial data related to routine services shall be used for statistical purposes.

SCHEDULE NF-1
PROVIDER INFORMATION

PROVIDER NAME: _____ PROVIDER NUMBER: _____

Period from: _____ to _____

Leap Year ☐ 366 365 ☐

Street Address

P. O. Box

City

State

Zip Code _____

Phone

Fax

Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended 01/01/2000 and to the best of my knowledge and belief, they are true and accurate statements prepared from the books and records of_____ in accordance with applicable program directives, except as noted.

(Print) _____
Officer or Administrator of Facility

(Signed) _____
Officer or Administrator of Facility

_____
Title

SCHEDULE NF-2
WAGE AND SALARY INFORMATION

PROVIDER NAME: FYE: 01/01/2000
PROVIDER NUMBER:

Pay period start date: _____ End date: _____

A. Wage Information

| Cost Category | Hours Paid | Hours Worked | Wages Paid |
|---|---|---|---|
| A. RN | 0 | 0 | $0 |
| B. LPN | 0 | 0 | $0 |
| C. Aides | 0 | 0 | $0 |
| D. Director of Nursing | 0 | 0 | $0 |
| E. Activities | 0 | 0 | $0 |
| F. Medical Records | 0 | 0 | $0 |
| G. Dietary | 0 | 0 | $0 |
| H. Housekeeping/Laundry | 0 | 0 | $0 |
| I. Social Services | 0 | 0 | $0 |
| J. Maintenance | 0 | 0 | $0 |
| Total | 0 | 0 | $0 |

B. Contracted Services

| Cost Category | Hours Paid | Hours Worked | Wages Paid |
|---|---|---|---|
| A. RN | 0 | 0 | $0 |
| B. LPN | 0 | 0 | $0 |
| C. Aides | 0 | 0 | $0 |
| Total | 0 | 0 | $0 |

C. Benefits Paid for by Nursing Facility

| | Totals taken from FYE 01/01/2000 |
|---|---|
| Health Insurance | $0 |
| Life Insurance | $0 |
| Retirement | $0 |
| Workers Compensation | $0 |
| FICA | $0 |

SCHEDULE NF-3
STAFF INFORMATION

PROVIDER NAME:
PROVIDER NUMBER

FYE: 01/01/200(

Effective Date 1-1-00

Approved Date Aug 10, 2001

| Patient Census | Number of Patient Days | | | | | | |
|---|---|---|---|---|---|---|---|
| | 09/13/99 | 09/14/99 | 09/15/99 | 09/16/99 | 09/17/99 | 09/18/99 | 09/19/99 |
| | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

| Staff Category | Number of Staff on Payroll | | | | | | |
|---|---|---|---|---|---|---|---|
| | 09/13/99 | 09/14/99 | 09/15/99 | 09/16/99 | 09/17/99 | 09/18/99 | 09/19/99 |
| RN | | | | | | | |
| RN Staffing – Day | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RN Staffing – Evening | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| RN Staffing – Overnight | 0 | 0 | 0 | 0 | 0 | 0 | |
| LPN | | | | | | | |
| LPN Staffing - Day | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| LPN Staffing – Evening | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| LPN Staffing–Overnight | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Aides | | | | | | | |
| Aide Staffing – Day | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Aide Staffing – Evening | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Aide Staffing - Overnight | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Food Service | | | | | | | |
| Food Service Workers – Day | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Food Service Workers – Evening | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Support Personnel | | | | | | | |
| Housekeeping/Laundry Service Workers | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Social Services Worker | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Activities Worker | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Medical Records Worker | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Maintenance Worker | | | | | | | |
| Director of Nursing | | | | | | | |

TN No. 00-04
Supersedes
TN No. 96-10

SCHEDULE NF-7
ALLOCATION STATISTICS

PROVIDER NAME:
PROVIDER NUMBER:

FYE: 01/01/2000

| Ancillary Charges | (1) TOTAL | (2) MEDICAID | (3) MEDICAID % |
|---|---|---|---|
| PHYSICAL THERAPY | $0 | $0 | 0.0000% |
| X-RAY | $0 | $0 | 0.0000% |
| LABORATORY | $0 | $0 | 0.0000% |
| OXYGEN/RESP. THERAPY | $0 | $0 | 0.0000% |
| SPEECH | $0 | $0 | 0.0000% |
| OCCUPATIONAL THERAPY | $0 | $0 | 0.0000% |
| TOTAL | $0 | $0 | |

| OCCUPANCY STATISTICS | (1) | (2) | (3) |
|---|---|---|---|
| LICENSED BEDS AT BEGINNING OF PERIOD | 0 | 0 | 0 |
| LICENSED BEDS AT END OF PERIOD | 0 | 0 | 0 |
| ?????? OCCUPANCY | 0 | 0 | 0 |
| ?????? PATIENT DAYS | 0 | | |
| ???? KMAP OCCUPANCY | 0 | | |

BED DAYS AVAILABLE – CERTIFIED NURSING FACILITY ONLY

| Beginning Date | Ending Date | Days | | Beds | | Bed Days Available |
|---|---|---|---|---|---|---|
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | | 0 | X | 0 | = | |
| | TOTAL DAYS | 0 | | TOTAL BED DAYS AVAILABLE | | 0 |

SCHEDULE NF-8
MISCELLANEOUS INFORMATION

PROVIDER NAME: TFY: 07/01/2000
PROVIDER NUMBER:

Current Ownership
List the current owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

| Name | Percent Owned |
|---|---|

Has the facility had a change of ownership in the past fiscal year? Change of ownership is defined as the transfer of the assets of a facility. The sale of stock in a facility does not constitute a change in ownership.

Yes ☐ No ☐

If yes, indicate the new owners and the percent owned. If the facility is corporately owned, list the officers of the company and their respective title.

| Name | Percent Owned |
|---|---|

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: *I).* 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 Global Insight 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 1:755

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.

F. 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.

G. 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 483.1 0(c)(8)(ii).

H. 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 or service that a charge will be made in writing that there will be a charge and the amount of the charge.

I. 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.

J. 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 1474.

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 a]l 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.

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

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

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

   a. Raw food costs, not including preparation;
   b. Direct costs of other care-related services; such as social services and resident activities;
   c. 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;
   d. 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.

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

   a. Dietary Services
   b. 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 shall 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.
   c. Housekeeping
   d. Plant Operation and Maintenance
   e. General and Administrative Services

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

a. Depreciation on building and fixtures
b. Depreciation on equipment
c. Capital related interest expense
d. Rent

4. 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- MR/DD.

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 (100) 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.

3. A facility shall he 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 Data Resources, Inc. 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 costs.

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 Data Resources, Incorporated (DRI) 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 preauthorizations 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 1, 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 which shall be reimbursed through the pharmacy program) fixed rate which shall be set at $475 per diem for services provided in the brain injury unit. The rates shall be increased or decreased based on the Global Insight Healthcare Cost Review, 1st Quarter Edition Index from the CMS Nursing Home without Capital Market Basket, Moving Average using the second quarter in the rate year.
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) negotiated. 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
(f) 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 Data Resources, Inc. inflation factor for the rate year beginning July 1, 1997.

C. FEDERALLY DEFINED SWING BEDS

A federally defined swing bed shall meet the requirements pursuant to 42 CFR 482.66.
A federally defined swing bed shall be reimbursed pursuant to 42 CFR 447.280. -

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 he 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
5. or field audit. 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.

A. 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 tr 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 MEDICAREIMEDICAID 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 Long Term Care shall perform an initial desk review's of the report. During the desk review process, Medicaid staff 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 clarity 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 pall 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. It is not possible to include the treatment of all items in this manual. If a provider presents a question concerning the treatment of cost not specifically covered, or desires clarification of information in this manual, 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(l) each provider's allowable costs of producing services, and (2) an apportionment of these costs between the Medicaid Program and other payors.

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 o 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 in this manual, 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 (I) 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 (j) 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 of the American Hospital Association's "Estimated Useful Lives of Depreciable Hospital Assets" shall he 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 in this manual, interest expense shall be an allowable cost pursuant to 42 CFR 4 13.153 and it is both necessary and proper in accordance with the provisions of this manual.

B. DEFINITIONS.

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 1, 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. For facilities classified as Skilled

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 1, 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 1, 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 1, 1985 does not exceed S3,000,000 annually. Any reduction of allowable interest based on the $3,000,00() 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 (1) 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 ORGANIZATION 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

A. PRINCIPLE. Bad debts, charity, and courtesy allowances are deductions from revenue and shall not be included in allowable cost.

B. DEFINITIONS.

1. “Bad Debts” means a debt considered to be uncollectible from “accounts receivable” and “notes receivable” that were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the rendering of services, and are collectible in money in the relatively near future.

2. “Charity allowances” means an allowance or reduction in charges made by the provider of services because of the indigence or medical indigence of the resident.

3. “Courtesy Allowances” means an allowance that indicates a reduction in charges in the form of an allowance to physicians,

clergy, members of religious orders, and others as approved by the governing body of the facility, for services received from the facility. Employee fringe benefits, such as hospitalization and personnel health program, shall not be considered to be courtesy allowances.

C. NORMAL ACCOUNTING TREATMENT - REDUCTION IN REVENUE. Bad debts, charity, and courtesy allowances represent reductions in revenue. The failure to collect charges for services rendered does not add to the cost of providing the services. These costs have already been incurred in the production of the services.

D. CHARITY ALLOWANCES. Charity allowances have no relationship to recipients of the Medicaid Program and shall not be allowable costs.

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

A. PRINCIPLE. Costs incurred for research purposes, over and above usual resident care, shall not be included as allowable costs.

B. APPLICATION. If research is conducted in conjunction with and as part of the care of residents, the costs of usual resident care shall be allowable to the extent that costs are not met by funds provided for the research. Under this principle, studies, analyses, surveys, and related activities to serve the facilities administrative and program needs shall not be excluded as allowable costs.

SECTION 550. GRANTS, GIFTS, AND INCOME FROM ENDOWMENTS

A. PRINCIPLE. Unrestricted grants, gifts, and income from endowments shall not be deducted from operating costs in computing reimbursable cost. Grants, gifts, or endowment income designated by a donor for paying specific operating costs shall be deducted from the particular operating cost or group of costs.

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

A. PRINCIPLE. The value of services performed on a regularly scheduled basis by persons (in positions customarily held by full-time employees) as non-paid workers under arrangements without direct remuneration from the provider shall be allowed as an operating expense for the determination of allowable cost subject to limitations contained in paragraph (B) of this section. The amounts allowed shall not exceed those

paid others for similar work. Amounts shall be identifiable in the records of the facilities as a legal obligation for operating expense. Non-paid workers hired under arrangements with a Cabinet for Health Services authorized work experience program shall qualify for the purposes of the principles in this section.

B. LIMITATIONS - SERVICES OF NON-PAID WORKERS. The service shall be performed on a regular, scheduled basis in positions customarily held by full-time employees and necessary to enable the provider to carry out the functions of normal resident care and operation of the facility. The value of services of a type for which facilities generally do not remunerate individuals performing those services shall not be allowed as a reimbursable cost under the Medicaid Program. For example, donated services of individuals in distributing books and magazines to residents, or in serving in a facility canteen or cafeteria or in a facility gift shop shall not be reimbursed.

C. APPLICATION. The following illustrates how a facility shall determine an amount to be allowed under this principle: The prevailing salary for a lay nurse is $5,000 for the year. The lay nurse receives no maintenance or special perquisites. A nun working as a nurse engaged in the same activities in the same facility receives maintenance and special perquisites which cost the facility $2,000 and are included in the facility's allowable operating costs. The facility may then include in its records and additional $3,000 to bring the value of the services rendered to $5,000. The amount of $3,000 shall be allowed if the facility assumes obligation for the expense under a written agreement with the sisterhood or other religious order covering payment by the facility for the services.

D. APPLICATION

1 Unrestricted funds, cash or otherwise, are generally the property of the provider to be used in any manner its management deems appropriate and shall not be deducted from operating costs. It would be inequitable to require providers to use the unrestricted funds to reduce the payments for care. The use of these funds is generally a means of recovering costs that are not otherwise recoverable. However, any interest earned on these funds shall be subject to the interest offset provisions of this manual.

2. Donor-restricted funds that are designated for paying certain operating expenses shall apply and serve to reduce these costs or groups of costs and benefit all residents who use the services covered by the donation. If costs are not reduced, the facility would secure reimbursement for the same expense twice; it would be reimbursed through the donor-restricted contributions as well as from residents and the Medicaid Program.

SECTION 570. PURCHASE DISCOUNTS AND ALLOWANCES AND REFUNDS OF EXPENSES

A. PRINCIPLE. Discounts and allowances received on purchases of goods or services are reductions of the costs to which they relate. Similarly, refunds of previous expense payments are reductions of the related expense.

B. DEFINITIONS.

1. "Discounts" means general reductions granted for the settlement of debts.
2. "Allowances" means deductions granted for damage, delay shortage, imperfection, or other causes, excluding discounts and returns.
3. "Refunds" means an amount paid back or credits allowed because of over collection.

C. NORMAL ACCOUNTING TREATMENT - REDUCTION OF COSTS.

All discounts allowances, and refunds of expenses are reductions in the cost of goods or services purchased and are not income. When they are received in the same accounting period in which the purchases were made or expenses were incurred, they shall be used to reduce the purchases or expenses of that period. However, if they are received in a Later accounting period, they shall be used to reduce the comparable purchases or expenses in the period in which they are received.

SECTION 580. COST TO RELATED ORGANIZATIONS

A. PRINCIPLE. Cost applicable to services, facilities, and supplies furnished to the provider by organizations related to the provider by common ownership or control are included in the allowable cost of the provider and is the cost of the related organization. However, the cost shall not exceed

the price of comparable services, facilities, or supplies that could be purchased elsewhere.

B. DEFINITIONS.

1. "Related to Provider" means that the provider, to a significant extent, is associated or affiliated with, or has control of, or is controlled by the organization furnishing the services, facilities, or supplies.

2. "Common ownership" means a relationship shall be considered to exist when an individual, including husband, wife, father, mother, brothers, sisters, sons, daughters, aunts, uncles, and in-laws, possesses five (5) percent or more of ownership or equity in the facility and the supplying business. A relationship shall also be considered to e'cist when it can be demonstrated that an individual or individual's control or influence management decisions or operations of the facility and the supplying business.

3. "Control" means if an individual or an organization has the power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or facility.

C. APPLICATION. If the provider obtains items of services, facilities, or supplies from an organization, even though it is a separate legal entity, and the organization is deemed to be a related organization, in effect the items are obtained from itself. Reimbursable cost shall include the cost for these items at the cost to the supplying organization. However, if the price in the open market for comparable services, facilities, or supplies is lower than the cost to the supplier, the allowable cost to the provider shall not exceed the market price. An example would be a corporation building a nursing home and then leasing it to another corporation controlled by the owner.

D. EXCEPTION. An exception is provided to this general principle if the provider demonstrates by convincing evidence to the satisfaction of the Department for Medicaid Services that the supplying organization is a bona fide separate organization; that fifty-one (51) percent of the supplier's business activity of the type carried on with the facility is transacted with persons and organizations other than the facility and its related organizations and there is an open, competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by facilities such as the provider from other organizations and are not

a basic element of resident care ordinarily furnished directly to residents by facilities; and that the charge to the provider is in line with the charge for services, facilities, or supplies in the open market and not more than the charge made under comparable circumstances to others by the organization for services, facilities, or supplies. In these cases, the charge by the supplier to the facility for services, facilities, or supplies shall be allowable as cost.

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 450.30.

SECTION 600. COST RELATED TO RESIDENT CARE

A. PRINCIPLE. All payments to facilities shall be based onthe 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

A. PRINCIPLE. A reasonable allowance of compensation for services of owners is an allowable cost, provided the services are actually performed and are a necessary function.

B. DEFINITIONS

1. "Reasonableness" requires the compensation allowance:
   a. Be an amount as would ordinarily be paid for comparable services by comparable facilities;
   b. Depend upon the facts and circumstances of each case; and,
   b. Be pertinent to the operation and sound conduct of the facility.

2. "Necessary" requires had the owner not rendered the services, the facility would have had to employ another person to perform the services.

3. "Owner" means as any person or related family member (as specified below) with a cumulative ownership interest of five (5) percent or more. Members of the immediate family' of an owner, include husband, wife, father, mother, brothers, sisters. sons, daughters, aunts, uncles, and in-laws and shall be treated as owners for the purpose of compensation.

4. "Compensation" means the total benefit received by the owner, including but not limited to: salary amounts paid for managerial, administrative, professional and other services; amounts paid by

the facility for the personal benefit of the owner; the cost of assets and services received from the facility and deferred compensation.

C. APPLICATION. The cost of full-time owner-employees may be included as an allowable cost if the compensation is reasonably comparable to compensation for similar positions in the industry but shall not exceed the applicable compensation limit for owner-administrator. The compensation of part-time owner-employees performing managerial type functions shall be allowable to the extent that the compensation does not exceed the percent of time worked times eighty (80) percent of the applicable compensation limits for an owner-administrator.

Full-time owner-administrators and full -time owner-employees who perform non-managerial functions in facilities other than the facility that they are primarily associated shall, for Medicaid purposes, be limited to reasonable compensation of not more than fourteen (14) hours per week in addition to the salary in the facility with which they are primarily associated. To be considered reasonable compensation, the owner shall prove performance of a necessary function and be able to document the time claimed for compensation. If managerial functions are performed in a non-primary facility by the full-time owner-administrator or full-time owner-employee of another facility, the cost of the services shall not be allowed for purposes of the Medicaid Program.

Compensation for services requiring a licensed or certified professional performed on an intermittent basis shall not be considered a part of compensation, nor shall it be limited to the application of the owner-administrator compensation schedule, if the professional services (e.g. legal services) would have necessitated the procurement of another person to perform the services.

D. COMPENSATION LIMITATION. Compensation for an owner-administrator shall be limited based on the total licensed beds of the facility in accordance with the following schedule:

| LICENSED BEDS COMPENSATION | MAXIMUM |
|---|---|
| 0-50 | $33,500 |

| | |
|---|---|
| 51-99 | $38,500 |
| 100-149 | $43,000 |
| 150-199 | $51,300 |
| 200+ | $52,600 |

This schedule shall be in effect for the period from July 1. 1991 through June .30, 1992. The compensation maximum shall be increased on July of each year by the Inflation Factor Index for wages and salaries Data Resources, Inc.). The Department for Medicaid Services shall utilize the moving average for the coming July 1 - June 30 fiscal year based on the latest inflation data available. The adjusted amounts shall be published annually in a reimbursement letter to all cost-based facility providers. Perquisites routinely provided to all employees and board of director's fees shall not be considered in applying owner s compensation limits

E. OTHER REQUIREMENTS

1. SOLE PROPRIETORSHIPS AND PARTNERSHIPS

The allowance of compensation for services of sole proprietors and partners shall be the amount determined to be the reasonable value of the services rendered (not to exceed the amount clammed for these services on the annual cost reports submitted by the facility. The allowance shall be an allowable cost regardless of whether there is any actual distribution of profits or other payments to the owner. The operating profit (or loss) of the facility shall not affect the allowance of compensation for the owners services.

2. CORPORATIONS.

To be included in allowable costs, compensation for services rendered as an employee, officer, or director by a person owning stock in a corporate provider shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which the compensation is earned or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid compensation shall not be included in allowable costs, either in the period earned or in the period when actually paid. For this purpose, an instrument to be negotiable shall be in writing and signed, shall contain an unconditional promise or other to pay a certain sum of money on demand or at a fixed and determinable future time and shall he payable to order or to bearer.

3. ACCRUED EXPENSES PAYABLE.

To be included in allowable costs, an accrued expense payable to an officer, direcior, stockholder, organization or other party or parties having control shall be paid (by cash, negotiable instrument, or in-kind) during the cost reporting period in which it has been incurred or within seventy-five (75) days thereafter. If payment is not made during this time period, the unpaid expense shall not be included in allowable costs, either in the period incurred or in the period when actually paid.

4. DEFINITIONS

a. "Control" shall exists if an individual or an organization has the ability, directly or indirectly, to influence, manage or direct the actions or policies of the provider regardless of ownership interest.

b. "Negotiable Instrument" means the negotiable instrument shall be in writing and signed, shall contain an unconditional promise or order to pay a certain sum of money on demand or at a fixed and determinable future time, and shall be payable to order or to bearer.

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 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 unco-mingled, 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 arid 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 suctioning1 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 outlined in this part of the Cost-Based Facility Reimbursement Manual took effect July 1. 1991 rate setting. The reimbursement system in effect as of July 1, 1990 shall remain in effect for Intermediate Care Facilities for the Mentally Retarded and Developmentally Disabled (ICFMRIDD) through June 30, 1991 with the following exceptions:

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

The intent of this reimbursement system is to recognize the reasonable costs associated with the services and level of care provided by ICF—MR 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 stated in the Cost-Based Facility Reimbursement Manual shall be applicable to the ICF- MR/DD facilities. Psychological and psychiatric services shall be billed as ancillary services by an ICF-MR/DD.

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/MR/DD 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/MR/DDs by the total aggregate cost report days for state owned or operated ICF/MR/DDs. 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 Global Insight 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 Global Insight 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 non-governmental ICF/MR/DDs shall be calculated using the same method as the state owned or operated ICF/MR/DDs; 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/MR/DD 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, page 28 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 I, 1976, shall be determined in accordance with the policies outlined in the Cost-Based Facility Reimbursement Manual.

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 I. 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-MRs shall not be an allowable expense for reimbursement purposes. Education services provided in facilities or areas within an ICF - MR 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 he excluded for Medicaid reimbursement, whether provided by state employees, by staff of the ICF-MR 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 LEP 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. If, 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, 1991 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 he designed for dual licensed pediatrics facilities that are providing services to Medicaid recipients and shall be reimbursed by the Department for Medicaid Services. Except as specified in this manual supplement, policies and procedures as stated in the Department for Medicaid Services Cost-Based Facility Reimbursement Manual. 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 1. SCHEDULE A - CERTIFICATION AND OTHER DATA;

This schedule shall be completed by all facilities.

A. TYPE OF CONTROL. In 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 tc 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 cr 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 3 1. 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 lines33 th.rough48.

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 I. 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-i. 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 1, 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-I - 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-l 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-l 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-l 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-l - 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 uretheral 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). Multiple 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 I 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 1, 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 1, 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 facility2 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 I 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-l 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-l 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.

D. 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.

E. 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 I 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-l, Lines 1-33; Schedule D-2, Lines 1- 30; and D-3, Lines 57-1 30, 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 I: 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 I by the sum of Lines I 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 I and 2 shall usually agree to entities on the salary lines of Schedule D-l. If the Schedule F, Ratio A salary figures do not agree to Schedule D-l 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-l 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 1, 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 I 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 1.
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.xxxx%).
d. Column 4, Line 10: The entry to this lineha11 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 1 by Line 3 in Column I.

D Section D - Ancillary Charges

1. Column 1: Enter the total charges for each type of ancillary service on Lines I 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 I through 7. Add Lines I 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 1 through 7. Add Lines I through 7 and total on Line 8.
5. Column 5. For each Line I 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.x%).
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 Pr

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____ Leap Year ☐ 365 ☐

To: _____

A. Type of Contract

| 1. Voluntary Non-Profit | | 2. Proprietary | | 3. Government | |
|---|---|---|---|---|---|
| Church | ☐ | Individual | ☐ | ☐ | State_____ |
| Other (Specify) | ☐ | Partnership | ☐ | ☐ | County_____ |
| _____ | | Corporation | ☐ | ☐ | City_____ |
| _____ | | Other (Specify) | ☐ | ☐ | Other (Specify) _____ _____ |

B. Statement of cost of services from Related Organizations

1. In the amount of cost to be reimbursed by the Medicaid Program, are any cost included which are the result of transactions with a related organization?

Yes ☐ No ☐ (IF "Yes" complete parts C & D). All Vendors are to complete E & F, if applicable.

C. Cost Incurred as the result of transactions with related organizations.

| Schedule | Line # | Item | Amount |
|---|---|---|---|
| | | | |

D. Name & percent of direct or indirect ownership of the related organization.

| Name of Owner | Name of Related Organization | Percent |
|---|---|---|
| | | |

E. Statement of Compensation of Owners

| Name | Title & Function | Percent of Customary Work Week Devoted to Business | Partners % of Operating Profit or Loss | Corp Ofc % of Vendor's Stock Owned | Total Compensation |
|---|---|---|---|---|---|
| | | | | | |

ANNUAL COST REPORT
SCHEDULE A
CERTIFICATION AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

For the Period From: _____
To: _____

F. Statement of Compensation Paid to Administrators and/or Assistant Administrators (Other than Owners).

| Name | Title | Percent of Customary Work Week Devoted to Business | Percent Of Period Employed | Total Compensation For the Period |
|---|---|---|---|---|
| | | | | |

G. Has the facility has a change of ownership in the past fiscal year? A change of ownership is defined as the transfer of assets of a facility. The sale of stock in a facility does not constitute a change of ownership.

Yes ☐ No ☐

If yes, indicate the new owners and the percent owned. (If corporate owned, not individuals.)

| Name | Percent Owned |
|---|---|
| | |

H. Certification by Officer of Facility

I HEREBY CERTIFY that I have examined the accompanying Kentucky Medicaid Cost Report for the period ended _____ and that, to the best of my knowledge and belief, they are true and correct statements prepared from the books and records of _____ in accordance with applicable program directives, except as noted.

(Signed) _____
Officer or Administrator of Facility

_____
Title

ANNUAL COST REPORT
SCHEDULE B
STATEMENT OF INCOME AND EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE

| | | |
|---|---|---|
| 1. | Total Patient Revenues | |
| 2. | Less Allowances and discounts on patients' accounts | |
| 3. | Net Patient Revenues | $ |
| 4. | Less: Total operating expenses | |
| 5. | Net income from services to patients | $ |
| | OTHER INCOME | |
| 6a. | Unrestricted contributions, donations, bequests, etc. | |
| 6b | Restricted contributions, donations, bequests, etc | |
| 7a. | Income from unrestricted investments | |
| 7b, | Income from restricted investments | |
| 8, | Vending machine commission | |
| 9. | Revenue from meals sold to employees and guests | |
| 10. | Revenue from sale of drugs, supplies, etc. sold to non-patients | |
| 11. | Revenue from telephone and telegraph services | |
| 12. | Revenue from rental of non-patient facilities | |
| 13. | Revenue from Beauty/Barber Shop | |
| 14. | Purchase discounts | |
| 15. | Other (specify) | |
| 16, | | |
| 17, | | |
| 18, | | |
| 19, | | |
| 20, | | |
| 21, | | |
| 22, | | |
| 23, | | |
| 24, | | |
| 25, | | |
| 26, | | |
| 27, | | |
| 28, | | |
| 29, | | |
| 30, | | |
| 31. | Total other income | |
| 32. | Total of line 5 and line 31 | |
| 33. | | |
| 34. | | |
| 35. | | |
| 36. | | |
| 37. | | |
| 38. | | |
| 39 | | |
| 40. | | |
| 41. | | |
| 42. | | |
| 43. | | |
| 44. | | |
| 45. | | |
| 46. | | |
| 47. | | |
| 48. | | |
| 49. | Total Other Expenses | |
| 50. | NET INCOME FOR THE PERIOD (line 32 less line 49) | |

ANNUAL COST REPORT
SCHEDULE C
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

| | | (1) | (2) | (3) |
|---|---|---|---|---|
| | **ASSETS** | | | |
| | | Per Books | Adjustments | Balance |
| | Current Assets | | | $ |
| 1. | Cash | | | $ |
| 2. | Notes and Accounts Receivable | | | $ |
| 3. | Other Receivables | | | $ |
| 4. | Less Allowance for Uncollectable Accounts | | | $ |
| 5. | Inventory | | | $ |
| 6. | Prepaid Expenses | | | $ |
| 7. | Investments | | | $ |
| 8. | Other (Specify | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| 9. | *Total Current Assets* | $ | $ | $ |
| | Fixed Assets | | | |
| | | | | $ |
| 10. | Land | | | $ |
| 11. | Building and Leasehold Improvements | | | $ |
| 12. | Less Accumulated Depreciation | | | $ |
| 13. | Fixed Equipment | | | $ |
| 14. | Less Accumulated Depreciation | | | $ |
| 15. | Major Movable Equipment | | | $ |
| 16. | Less Accumulated Depreciation | | | $ |
| 17. | Motor Vehicles | | | $ |
| 18. | Less Accumulated Depreciation | | | $ |
| 19. | Minor Equipment | | | $ |
| 20. | Less Accumulated Depreciation | | | $ |
| | | | | $ |
| 21. | *Total Fixed Assets* | $ | $ | $ |
| | Other Assets | | | |
| | | | | $ |
| 22. | Investments | | | $ |
| 23. | Lease Deposits | | | $ |
| 24. | Due from Owners or Officers (Specify) | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| 25. | Other (Specify) | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| | | | | $ |
| 26. | *Total Other Assets* | $ | $ | $ |
| 27. | Total Assets | $ | $ | $ |

ANNUAL COST REPORT
SCHEDULE C (cont.)
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL

VENDOR NAME: VENDOR NUMBER: FYE

| | | (1) | (2) | (3) |
|---|---|---|---|---|
| | LIABILITIES | | | |
| | Current Utilities | Per Books | Adjustments | Balance |
| 28. | Accounts Payable | | | $ |
| 29. | Notes Payable | | | |
| 30. | Current Portion of Long Term Debt | | | |
| 31. | Salaries and Fees Payable | | | |
| 32. | Payroll Taxes Payable | | | |
| 33. | Income Taxes Payable | | | |
| 34. | Deferred Income Payable | | | |
| 35. | Other (Specify) | | | |
| 36. | *Total Current Liabilities* | $ | $ | $ |
| | Long Term Liabilities | | | |
| 37. | Mortgage Payable | | | $ |
| 38. | Notes Payable | | | |
| 39. | *Total Long Term Liabilities* | $ | | $ |
| 40. | Total Liabilities | $ | $ | $ |
| | **CAPITAL AND OWNERS' EQUITY** | | | |
| 41. | Common Stock | | | $ |
| 42. | Preferred Stock | | | |
| 43. | Treasury Stock | | | |
| 44. | Retained Earnings | | | |
| 45. | Other (Specify) | | | |
| 46. | *Total Capital and Owners' Equity* | $ | $ | $ |
| 47. | Total Liabilities and Capital | $ | $ | $ |

ANNUAL COST REPORT
SCHEDULE C-1
BALANCE SHEET AND COMPUTATION OF EQUITY CAPITAL ADUJUSTMENTS

VENDOR NAME: VENDOR NUMBER: FYE

| | EXPLANATION | AMOUNT | CLASSIFICATION ADJUSTED ACCOUNT | LINE |
|---|---|---|---|---|
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
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| 53 | | | | |
| 54 | | | | |
| 55 | | | | |
| 56 | TOTAL | | | |

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ANNUAL COST REPORT – SCHEDULE D-1- NURSING SERVICES COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. |
|---|---|---|---|---|---|---|---|---|
| 1 | Director of Nursing Salary | | | | | | | |
| 2 | R.N. Salaries | | | | | | | |
| 3. | L.P.N. Salaries | | | | | | | |
| 4. | C.M.A. Salaries | | | | | | | |
| 5. | Aides Salaries | | | | | | | |
| 6 | Other Salaries | | | | | | | |
| 7 | Other Salaries | | | | | | | |
| 8 | Other Salaries | | | | | | | |
| 9 | *Subtotal - Salaries* | | | | | | | |
| 10 | Employee Benefits Reclassification | | | | | | | |
| 11 | Nursing Contracted Services | | | | | | | |
| 12 | Medical Records Salaries | | | | | | | |
| 13 | Medical Director Fees | | | | | | | |
| 14 | Pharmacy Consultant Fees | | | | | | | |
| 15. | Physician Services | | | | | | | |
| 16. | Nursing Education & Training | | | | | | | |
| 17. | Nursing Travel Expense | | | | | | | |
| 18. | Medical Supplies | | | | | | | |
| 19. | Adult Diapers & Underpads | | | | | | | |
| 20. | Nursing Equipment Rental | | | | | | | |
| 21. | Nursing Small Equip. Purchases | | | | | | | |
| 22. | Other Expenses | | | | | | | |
| 23 | Other Expenses | | | | | | | |
| 24 | Other Expenses | | | | | | | |
| 25 | Other Expenses | | | | | | | |
| 26 | Other Expenses | | | | | | | |
| 27 | Other Expenses | | | | | | | |
| 28 | Other Expenses | | | | | | | |
| 29 | Other Expenses | | | | | | | |
| 30 | Other Expenses | | | | | | | |
| 31 | Other Expenses | | | | | | | |
| 32 | Other Expenses | | | | | | | |
| 33 | Other Expenses | | | | | | | |
| 34 | *Total* | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-2- OTHER CARE RELATED COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. |
|---|---|---|---|---|---|---|---|---|
| 1 | Activities Salaries | | | | | | | |
| 2 | Social Services Salaries | | | | | | | |
| 3. | Other Salaries | | | | | | | |
| 4. | Other Salaries | | | | | | | |
| 5. | Other Salaries | | | | | | | |
| 6 | *Subtotal - Salaries* | | | | | | | |
| 7 | Employee Benefits Reclassification | | | | | | | |
| 8 | Activities Supplies | | | | | | | |
| 9 | Social Services Supplies | | | | | | | |
| 10 | Training & Education Expense | | | | | | | |
| 11 | Travel Expense | | | | | | | |
| 12 | Other Expenses | | | | | | | |
| 13 | Other Expenses | | | | | | | |
| 14 | Other Expenses | | | | | | | |
| 15. | Other Expenses | | | | | | | |
| 16. | Other Expenses | | | | | | | |
| 17. | Other Expenses | | | | | | | |
| 18. | Other Expenses | | | | | | | |
| 19. | Other Expenses | | | | | | | |
| 20. | Other Expenses | | | | | | | |
| 21. | Other Expenses | | | | | | | |
| 22. | Other Expenses | | | | | | | |
| 23 | Other Expenses | | | | | | | |
| 24 | Other Expenses | | | | | | | |
| 25 | Other Expenses | | | | | | | |
| 26 | Other Expenses | | | | | | | |
| 27 | Other Expenses | | | | | | | |
| 28 | Other Expenses | | | | | | | |
| 29 | Other Expenses | | | | | | | |
| 30 | Other Expenses | | | | | | | |
| 31 | Raw Food | | | | | | | |
| 32 | *Total* | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. | (9) Ancillary Hospital-Based Facility Only |
|---|---|---|---|---|---|---|---|---|---|
| | Dietary | | | | | | | | |
| 1 | Dietary Salaries | | | | | | | | |
| 2 | Other Salaries | | | | | | | | |
| 3. | Other Salaries | | | | | | | | |
| 4. | Other Salaries | | | | | | | | |
| 5. | *Subtotal-Salaries* | | | | | | | | |
| 6 | Employee Benefits Reclassification | | | | | | | | |
| 7 | Dietary Consultant Fees | | | | | | | | |
| 8 | Dietary Supplies | | | | | | | | |
| 9 | Equipment Rental | | | | | | | | |
| 10 | Small Equipment Purchases | | | | | | | | |
| 11 | Other Dietary Expense | | | | | | | | |
| 12 | Other Dietary Expense | | | | | | | | |
| 13 | Other Dietary Expense | | | | | | | | |
| 14 | Other Dietary Expense | | | | | | | | |
| 15. | Other Dietary Expense | | | | | | | | |
| 16. | Other Dietary Expense | | | | | | | | |
| 17. | Other Dietary Expense | | | | | | | | |
| 18. | Other Dietary Expense | | | | | | | | |
| 19. | Other Dietary Expense | | | | | | | | |
| 20. | *Total Dietary Expense* | | | | | | | | |
| | Housekeeping & Plant Operation | | | | | | | | |
| 21. | Housekeeping Salaries | | | | | | | | |
| 22. | Plan Oper. & Maint. Salaries | | | | | | | | |
| 23 | Other Salaries | | | | | | | | |
| 24 | Other Salaries | | | | | | | | |
| 25 | Other Salaries | | | | | | | | |
| 26 | *Subtotal Salaries* | | | | | | | | |
| 27 | Employee Benefits Reclassification | | | | | | | | |
| 28 | Housekeeping Supplies | | | | | | | | |
| 29 | Plant Oper. & Maint. Supplies | | | | | | | | |
| 30 | Equipment Rental | | | | | | | | |
| 31 | Repairs & Maintenance Building | | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. | (9) Ancillary Hospital-Based Facility Only |
|---|---|---|---|---|---|---|---|---|---|
| 32 | Repairs & Maintenance - Equipment | | | | | | | | |
| 33 | Repairs & Maintenance- Grounds | | | | | | | | |
| 34 | Small Equipment Purchases | | | | | | | | |
| 35 | Gas | | | | | | | | |
| 36 | Electricity | | | | | | | | |
| 37 | *Water & Sewage* | | | | | | | | |
| 38 | Garbage Pick-up | | | | | | | | |
| 39 | Contracted Services | | | | | | | | |
| 40 | Pest Control Services | | | | | | | | |
| 41 | Property Taxes | | | | | | | | |
| 42 | Insurance-Property, Plant & Equip. | | | | | | | | |
| 43 | Other Hskg & Plant Op. | | | | | | | | |
| 44 | Other Hskg & Plant Op. | | | | | | | | |
| 45 | Other Hskg & Plant Op. | | | | | | | | |
| 46 | Other Hskg & Plant Op. | | | | | | | | |
| 47 | Other Hskg & Plant Op. | | | | | | | | |
| 48 | Other Hskg & Plant Op. | | | | | | | | |
| 49 | Other Hskg & Plant Op. | | | | | | | | |
| 50 | Other Hskg & Plant Op. | | | | | | | | |
| 51 | Other Hskg & Plant Op. | | | | | | | | |
| 52 | Other Hskg & Plant Op. | | | | | | | | |
| 53 | Other Hskg & Plant Op. | | | | | | | | |
| 54 | Other Hskg & Plant Op. | | | | | | | | |
| 55 | Other Hskg & Plant Op. | | | | | | | | |
| 56 | *Total Housekeeping & Plant Oper.* | | | | | | | | |
| | Laundry | | | | | | | | |
| 57 | Laundry Salaries | | | | | | | | |
| 58 | *Other Salaries* | | | | | | | | |
| 59 | Other Salaries | | | | | | | | |
| 60 | Other Salaries | | | | | | | | |
| 61 | *Subtotal - Salaries* | | | | | | | | |
| 62 | Employee Benefits Reclassification | | | | | | | | |
| 63 | Laundry Supplies | | | | | | | | |
| 64 | Linens & Bedding | | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. | (9) Ancillary Hospital-Based Facility Only |
|---|---|---|---|---|---|---|---|---|---|
| 65 | Laundry Contracted Services | | | | | | | | |
| 66 | Other Laundry Expense | | | | | | | | |
| 67 | Other Laundry Expense | | | | | | | | |
| 68 | Other Laundry Expense | | | | | | | | |
| 69 | Other Laundry Expense | | | | | | | | |
| 70 | Other Laundry Expense | | | | | | | | |
| 71 | Other Laundry Expense | | | | | | | | |
| 72 | Other Laundry Expense | | | | | | | | |
| 73 | Other Laundry Expense | | | | | | | | |
| 74 | Other Laundry Expense | | | | | | | | |
| 75 | *Total Laundry Expense* | | | | | | | | |
| 76 | Administrative & General | | | | | | | | |
| 77 | Salaries – Officers | | | | | | | | |
| 78 | Salaries – Administrator | | | | | | | | |
| 79 | Salaries – Office Staff | | | | | | | | |
| 80 | Other Salaries | | | | | | | | |
| 87 | Other Salaries | | | | | | | | |
| 82 | *Subtotal Salaries* | | | | | | | | |
| 83 | Management Fees | | | | | | | | |
| 84 | Home Office Costs | | | | | | | | |
| 85 | Board of Directors Fees | | | | | | | | |
| 86 | FICA | | | | | | | | |
| 87 | Workman's Compensation | | | | | | | | |
| 88 | Unemployment Insurance | | | | | | | | |
| 89 | Medical Insurance | | | | | | | | |
| 90 | Life Insurance | | | | | | | | |
| 91 | *Telephone* | | | | | | | | |
| 92 | Dues & Subscriptions | | | | | | | | |
| 93 | Office Supplies | | | | | | | | |
| 94 | Equipment Rental | | | | | | | | |
| 95 | Printing & Postage | | | | | | | | |
| 96 | Legal Fees | | | | | | | | |
| 97 | Accounting Fees | | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-3- OTHER OPERATING COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. | (9) Ancillary Hospital-Based Facility Only |
|---|---|---|---|---|---|---|---|---|---|
| 98 | Contracted Services | | | | | | | | |
| 99 | Utilization Review | | | | | | | | |
| 100 | Travel & Seminars | | | | | | | | |
| 101 | Advertising – Help Wanted | | | | | | | | |
| 102 | Advertising – Other | | | | | | | | |
| 103 | Small Equipment Purchases | | | | | | | | |
| 104 | Licenses & Fees | | | | | | | | |
| 105 | Interest Expense – Non-capital | | | | | | | | |
| 106 | Other Expense | | | | | | | | |
| 107 | Other Expense | | | | | | | | |
| 108 | Other Expense | | | | | | | | |
| 109 | Other Expense | | | | | | | | |
| 110 | Other Expense | | | | | | | | |
| 111 | Other Expense | | | | | | | | |
| 112 | Other Expense | | | | | | | | |
| 113 | Other Expense | | | | | | | | |
| 114 | Other Expense | | | | | | | | |
| 115 | Other Expense | | | | | | | | |
| 116 | Other Expense | | | | | | | | |
| 117 | Other Expense | | | | | | | | |
| 118 | Other Expense | | | | | | | | |
| 119 | Other Expense | | | | | | | | |
| 120 | Other Expense | | | | | | | | |
| 121 | Other Expense | | | | | | | | |
| 122 | Other Expense | | | | | | | | |
| 123 | Other Expense | | | | | | | | |
| 124 | Other Expense | | | | | | | | |
| 125 | Other Expense | | | | | | | | |
| 126 | Other Expense | | | | | | | | |
| 127 | Other Expense | | | | | | | | |
| 128 | Other Expense | | | | | | | | |
| 129 | Other Expense | | | | | | | | |
| 130 | HEALTH CARE PROVIDER TAX | | | | | | | | |
| 131 | *Total Admin & General Exp* | | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-4- CAPITAL COSTS

VENDOR NAME: VENDOR NUMBER: FYE

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjustments | (5) Adjusted Balance | (6) Direct Cost or Alloc. | (7) Certified Nursing Facility Alloc. Of Costs | (8) Non-Certified & Non-Nursing Fac. Alloc. Of Costs. | (9) Ancillary Hospital-Based Facility Only |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Depreciation – Building | | | | | | | | |
| 2 | Depreciation – Equipment | | | | | | | | |
| 3 | Interest Expense – Capital Related | | | | | | | | |
| 4 | Rent | | | | | | | | |
| 5 | Land Improvements | | | | | | | | |
| 6 | Leasehold Improvements | | | | | | | | |
| 7 | Amortization of Start up Costs | | | | | | | | |
| 8 | Other Capital Costs | | | | | | | | |
| 9 | Other Capital Costs | | | | | | | | |
| 10 | Other Capital Costs | | | | | | | | |
| 11 | Other Capital Costs | | | | | | | | |
| 12 | Other Capital Costs | | | | | | | | |
| 13 | Other Capital Costs | | | | | | | | |
| 14 | Other Capital Costs | | | | | | | | |
| 15 | Other Capital Costs | | | | | | | | |
| 16 | Other Capital Costs | | | | | | | | |
| 17 | Other Capital Costs | | | | | | | | |
| 18 | Other Capital Costs | | | | | | | | |
| 19 | Other Capital Costs | | | | | | | | |
| 20 | Other Capital Costs | | | | | | | | |
| 21 | Other Capital Costs | | | | | | | | |
| 22 | Other Capital Costs | | | | | | | | |
| 23 | *Total* | | | | | | | | |
| | Grand Totals | (2) | (3) | (4) | (5) | (6) | (7) | (8) | (9) |
| 24 | Totals of Schedules D-1 through D-4 | | | | | | | | |
| 25 | Total of Schedule of D-8, Column 8 | | | | | | | | |
| 26 | Total Routine CNF Cost | | | | | | | | |
| 27 | Totals from Schedule D-5 | | | | | | | | |
| 28 | Total Costs | | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE:

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjust-ments | (5) Adjusted Balance | (6) Direct Costs | (7) Indirect Costs | (8) CNF Indirect Costs |
|---|---|---|---|---|---|---|---|---|
| | Physical Therapy | | | | | | | |
| 1 | Physical Therapist Salaries | | | | | | | |
| 2 | Physical Therapist Asstnts, Salaries | | | | | | | |
| 3 | Physical Therapist Aides Salaries | | | | | | | |
| 4 | Other Salaries | | | | | | | |
| 5 | *Subtotal Salaries* | | | | | | | |
| 6 | Employee Benefits Reclassification | | | | | | | |
| 7 | Contracted Services | | | | | | | |
| 8 | Equipment Depreciation | | | | | | | |
| 9 | Other Expenses | | | | | | | |
| 10 | Other Expenses | | | | | | | |
| 11 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 3, Col 4) | | | | | | |
| 12 | *Total* | | | | | | | |
| | X-Ray | | | | | | | |
| 13 | Professional Salaries | | | | | | | |
| 14 | Other Salaries | | | | | | | |
| 15 | *Subtotal Salaries* | | | | | | | |
| 16 | Employee Benefits Reclassification | | | | | | | |
| 17 | Supplies | | | | | | | |
| 18 | Equipment Depreciation | | | | | | | |
| 19 | Other Expenses | | | | | | | |
| 20 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 4, Col. 4) | | | | | | |
| 21 | *Total* | | | | | | | |
| | Laboratory | | | | | | | |
| 22 | Professional Salaries | | | | | | | |
| 23 | Other Salaries | | | | | | | |
| 24 | *Subtotal Salaries* | | | | | | | |
| 25 | Employee Benefits Reclassification | | | | | | | |
| 26 | Supplies | | | | | | | |
| 27 | Equipment Depreciation | | | | | | | |
| 28 | Other Expenses | | | | | | | |
| 29 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 5, Col. 4) | | | | | | |
| 30 | *Total* | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE:

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjust-ments | (5) Adjusted Balance | (6) Direct Costs | (7) Indirect Costs | (8) CNF Indirect Costs |
|---|---|---|---|---|---|---|---|---|
| | Oxygen/Respiratory Therapy | | | | | | | |
| 31 | Respiratory Therapist Salaries | | | | | | | |
| 32 | Respiratory Therapist Assistant, Sal. | | | | | | | |
| 33 | Respiratory Therapist Aides Salaries | | | | | | | |
| 34 | Other Salaries | | | | | | | |
| 35 | *Subtotal Salaries* | | | | | | | |
| 36 | Employee Benefits Reclassification | | | | | | | |
| 37 | Supplies | | | | | | | |
| 38 | Equipment Depreciation | | | | | | | |
| 39 | Other Expenses | | | | | | | |
| 40 | Other Expenses | | | | | | | |
| 41 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 6, Col 4) | | | | | | |
| 42 | *Total* | | | | | | | |
| | Speech | | | | | | | |
| 43 | Professional Salaries | | | | | | | |
| 44 | Other Salaries | | | | | | | |
| 45 | *Subtotal Salaries* | | | | | | | |
| 46 | Employee Benefits Reclassification | | | | | | | |
| 47 | Equipment Depreciation | | | | | | | |
| 48 | Other Expenses | | | | | | | |
| 49 | Other Expenses | | | | | | | |
| 50 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 7, Col. 4) | | | | | | |
| 51 | *Total* | | | | | | | |
| | Other | | | | | | | |
| 52 | Professional Salaries | | | | | | | |
| 53 | Other Salaries | | | | | | | |
| 54 | *Subtotal Salaries* | | | | | | | |
| 55 | Employee Benefits Reclassification | | | | | | | |
| 56 | Equipment Depreciation | | | | | | | |
| 57 | Other Expenses | | | | | | | |
| 58 | Other Expenses | | | | | | | |
| 59 | Hospital-Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 8, Col. 4) | | | | | | |
| 60 | *Total* | | | | | | | |

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ANNUAL COST REPORT – SCHEDULE D-5 – ANCILLARY COSTS

VENDOR NAME: VENDOR NUMBER: FYE:

| | (1) | (2) Per Books | (3) Reclass-ifications | (4) Adjust-ments | (5) Adjusted Balance | (6) Direct Costs | (7) Indirect Costs | (8) CNF Indirect Costs |
|---|---|---|---|---|---|---|---|---|
| | Drugs | | | | | | | |
| 61 | Pharmacist Salaries | | | | | | | |
| 62 | Other Salaries | | | | | | | |
| 63 | *Subtotal Salaries* | | | | | | | |
| 64 | Employee Benefits Reclassification | | | | | | | |
| 65 | Drugs | | | | | | | |
| 66 | Equipment Depreciation | | | | | | | |
| 67 | Other Expenses | | | | | | | |
| 68 | Other Expenses | | | | | | | |
| 69 | Other Expenses | | | | | | | |
| 70 | Other Expenses | | | | | | | |
| 71 | Hospital Based Indirect Ancillary | (Sch. D-4, Line 24, Col. 9 X Sch. F, Section B, Line 9, Col 4) | | | | | | |
| 72 | *Total* | | | | | | | |

TN # 00-04
Supersedes
TN # 96-10

Approved AUG 10, 2001

Eff. Date 1-1-00

SCHEDULE D-6
RECLASSIFICATIONS OF EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE:

| Line | (1) Explanation | (2) Increase Amount | (3) Decrease Amount | (4) Cost Center Affected (Schedule & Line # Affected) (cc D3-1) |
|---|---|---|---|---|
| 1 | | | | |
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| 61 | *Total* | | | |

SCHEDULE D-7
RECLASSIFICATIONS OF EXPENSES

VENDOR NAME: VENDOR NUMBER: FYE:

| Line | (1) Explanation | (2) Basis for Adjustment (A) or (B) | (3) Amount | (4) Sch & Line # Affected (cc D3-!) |
|---|---|---|---|---|
| 1 | Laundry & Linen | | | |
| 2 | Employee & Guest Meals | | | |
| 3 | Gift, Flower & Coffee Shop | | | |
| 4 | Grants, Gifts, & Income Designated By the donor for a specific purpose | | | |
| 5 | Beauty & Barber Shop | | | |
| 6 | Excess Owners Compensation | | | |
| 7 | Telephone Serv (Pay Serv. Excluded) | | | |
| 8 | Radio & Television Service | | | |
| 9 | Vending Machine Commission | | | |
| 10 | Sale of drugs to other than Patients | | | |
| 11 | Sale of Medical & Surgical Supplies To other than Patients | | | |
| 12 | Sale of Medical Record & Abstracts | | | |
| 13 | Sale of Scrap, Waste, Etc. | | | |
| 14 | Rental of Quarters to Emp & Others | | | |
| 15 | Rental of Facility Space | | | |
| 16 | Trade, Qty, Time & Other Discounts | | | |
| 17 | Rebates & Refunds of Expenses | | | |
| 18 | Interest Not Allowed | | | |
| 19 | Recovery of Insured Loss | | | |
| 20 | Depreciation | | | |
| 21 | Gain or Loss of Disposition of Assets | | | |
| 22 | | | | |
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| 52 | | | | |
| 53 | *Total* | | | |

Attachment 4.19-D
Exhibit B
Page 86-S

ANNUAL COST REPORT – SCHEDULE E – ANCILLARY SETTLEMENT

VENDOR NAME: VENDOR NUMBER: FYE:

| | (1) | (2) Direct (From Sch. D-5, Col 6) | (3) Medicaid Direct | (4) Medicaid Payments | (5) Receivable From KMAP (Payable to KMAP) |
|---|---|---|---|---|---|
| 1 | Physical Therapy | | | | |
| 2 | X-Ray | | | | |
| 3 | Laboratory | | | | |
| 4 | Oxygen/Respiratory Therapy | | | | |
| 5 | Speech | | | | |
| 6 | Other | | | | |
| 7 | Drugs | | | | |
| 8 | *Total* | | | | |

Medicaid Services use only

TENTATIVE ☐ ANCILLARY

ANCILLARY ☐ SETTLEMENT ☐

TN # 00-04
Supersedes

Approved AUG 10, 2001

Eff. Date 1-1-00

STATISTICS

VENDOR NAME: FYE FYE

_____ _____ _____
DAYS MONTHS

VENDOR NUMBER:
_____

A. NURSING SALARIES Leap Year ☐ 365 ☐

| | | |
|---|---|---|
| 1 | CERTIFIED NURSING FACILITY | |
| 2 | OTHER | |
| 3 | CERT. NURSING FAC. PERCENTAGE | |

ALLOCATION METHOD:
PATIENT DAYS ☐ VALID TIME STUDY ☐
DIRECT COST ☐ DIRECT HOURS ☐
OTHER APPROVED METHOD ☐

B. SQUARE FOOTAGE

| | | (1) SQ. FT. | (2) PERCENT | (3) HOSPITAL-BASED SQ. FT. | (4) HOSPITAL-BASED PERCENT |
|---|---|---|---|---|---|
| 1 | CERT. NURSING FACILITY | | | | |
| 2 | OTHER | | | | |
| 3 | PHYSICAL THERAPY* | | | | |
| 4 | X-RAY* | | | | |
| 5 | LABORATORY* | | | | |
| 6 | OXYGEN/RESP. THERAPY* | | | | |
| 7 | SPEECH* | | | | |
| 8 | OTHER* | | | | |
| 9 | DRUGS* | | | | |
| 10 | TOTAL | | | | |

*For Hospital-Based Certified Nursing Facility Only

C. DIETARY

| | | MEALS | PERCENT |
|---|---|---|---|
| 1 | CERT. NURSING FACILITY | | |
| 2 | ALL OTHER | | |
| 3 | TOTAL | | |

ALLOCATION METHOD:
MEAL COUNT: ☐ 3*INPATIENT DAYS: ☐

D. ANCILLARY CHARGES

| | | (1) TOTAL | (2) CNF | (3) CNF % | (4) MEDICAID | (5) MEDICAID % |
|---|---|---|---|---|---|---|
| 1 | PHYSICAL THERAPY | | | | | |
| 2 | X-RAY | | | | | |
| 3 | LABORATORY | | | | | |
| 4 | OXYGEN/RESP. THERAPY | | | | | |
| 5 | SPEECH | | | | | |
| 6 | OTHER | | | | | |
| 7 | DRUGS | | | | | |
| 8 | TOTAL | | | | | |

E OCCUPANCY STATISTICS

| | | (1) CERTIFIED NURSING FACILITY | (2) OTHER LONG-TERM CARE | (3) ACUTE CARE |
|---|---|---|---|---|
| 1 | LICENSED BEDS AT BEGINNING OF PERIOD | | | |
| 2 | LICENSED BEDS AT END OF PERIOD | | | |
| 3 | BED DAYS AVAILABLE | | | |
| 4 | TOTAL PATIENT DAYS | | | |
| 5 | % OCCUPANCY | | | |
| 6 | KMAP PATIENT DAYS | | | |
| 7 | % KMAP OCCUPANCY | | | |

F ADDITIONAL STATISTICS

| | | |
|---|---|---|
| 1 | DIRECT ROUTINE NURSING HOURS – CERTIFIED NURSING FACILITY ONLY | |
| 2 | TOTAL DIRECT DIETARY HOURS | |
| 3 | TOTAL DIRECT HOUSEKEEPING HOURS | |

DISCLOSURE SECTION

VENDOR NAME: _____ VENDOR NUMBER: _____ FYE: _____

A. STATEMENT OF ORGANIZATIONS CONTRACTED WITH

| NAME | TYPE OF BUSINESS | DATE OF CONTRACT |
|---|---|---|

B PROTESTED AMOUNTS (NON-ALLOWABLE COST REPORT ITEMS)

| ITEM | AMOUNT | SCHEDULE AND LINE |
|---|---|---|

Timely Claims Payment

---

Definition of A Claim

(1) "Claim" means:

(a) For physician, podiatry, dental, vision care, hearing aid dealers, home health, primary care clinics, mental health center clinics, pharmacy, hospital outpatient, and independent laboratory services, a line item of service;

(b) For tuberculosis and mental hospital services, all services for one recipient within a bill; and

(c) For all other services, a bill for services.

State _____Kentucky_____

Requirements for Third Party Liability
Identifying Liable Resources

The Title XIX single state agency is committed to compliance with all third party recovery requirements, including those shown in 42 CFR 433, Subpart D, Third Party Liability. For purposes of clarification, we state herein that the $250 threshold applies only with regard to accident/trauma claims; there is a $25 threshold amount for waiver claims such as pharmacy; there is no threshold amount for all other claims. The Kentucky Department for Medicaid Services may look back three (3) years for payment for any healthcare item or services submitted not later than three (3) years after the date such item or service was provided.

(b) (1) An agreement has been developed with the Department for Social Insurance (DSI) for collecting and forwarding health insurance information for Kentucky's Title XIX recipients. The local DSI field worker collects TPL data during initial application and during the redetermination process. The information collected includes the name of the policy holder, relationship of policy holder to recipient, the social security number of the policy holder, the policy number, and type of coverage held and name and address of insurance company. The information is added daily to the TPL data base and claims are edited against the data each processing cycle. Social Security Numbers of absent parents are being obtained from Title IV-D agencies. Addresses of employers of absent parents are obtained from unemployment insurance.

Data exchanges have been arranged with Worker's Compensation and will be done quarterly. SWICA information is obtained during application and at least quarterly. SSA information is obtained during the application process from recipients for whom the information was not previously requested.

Data exchanges have been, and will continue to be, attempted as required by regulation with Motor Vehicle Registration.

(2) The state follows up within 30 days on all information obtained from SWIC, SSA wage and earnings files, and Title IV- A by entering any valid or appropriate data into the TPL avoidance file, or by utilizing the data for collection. The state will follow up the data exchanges with health insurors and worker's compensation files within sixty (60) days from the date of receipt of the tapes.

(3) The state has attempted, and will continue its efforts, to develop a state motor vehicle accident report file.

(4) Claims involving trauma diagnosis codes are processed in accordance with 42 CFR 433.138(3) and 433.139 with accumulated claims in excess of $250 pursued for possible third party payment or recovery. A monthly listing is produced which identifies all recipients for whom $250 or more has been paid within a prior ninety (90) day period with an indicator of trauma or accident. Each case is actively pursued for possible collection. The time frames within which incorporation of information from accident/trauma diagnosis code TPL procedures must be accomplished is thirty (30) days.

(5) Providers are not required to bill the third party in situations where the third party liability is derived from a parent whose obligation to pay support is being enforced by the State Title IV-D agency. Kentucky uses the pay and chase method.

(6) The state assures that the requirements of 42 CFR 433.145 through 433.148 are met for assignment for rights to benefits. Kentucky's statue KRS 205.624 (see Attachment 4.22-A, Exhibit A) requires assignment of third party payments. The application for Medical Assistance/AFDC and the Medical Assistance identification Card have a statement notifying the applicant/recipient of the third party assignment.

205.624. Assignment to cabinet by recipient of rights to third party payments - Right of recovery by cabinet. - (1) An applicant or recipient shall be deemed to have made to the cabinet an assignment of his rights to third party payments to the extent of medical assistance paid on behalf of the recipient under title XIX of the Social Security Act. The applicant or recipient shall be informed in writing by the cabinet of such assignment.

(2) The cabinet shall have the right of recovery which a recipient may have for the co4 of hospitalization, pharmaceutical services, physician services, nursing services, and other medical services not to exceed the amount of funds expended by the cabinet for such care and treatment of the recipient under the provisions of title XIX of the Social Security Act.

(a) If a payment for medical assistance is made, the cabinet, to enforce its right, may:

1. Intervene or join in an action or proceeding brought by the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court; or
2. Institute and prosecute legal proceedings against a third party who may be liable for the injury, disease, or disability, or against contractors, public or private, who may be liable to pay or provide medical care and services rendered to an injured, diseased, or disabled recipient, in state or federal court, either alone or in conjunction with the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors; or
3. Institute the proceedings in its own name or in the name of the injured, diseased, or disabled person, his guardian, personal representative, estate, dependents, or survivors.

(b) The injured, diseased, or disabled person may proceed in his own name, collecting costs without the necessity of joining the cabinet or the Commonwealth as a named party, provided the injured, diseased, or disabled person shall notify the cabinet of the action or proceeding entered into upon commencement of the action or proceeding. The injured, diseased, or disabled person must notify the cabinet of any settlement or judgment of his or her claim.

(c) In the case of an applicant for or recipient of medical assistance whose eligibility is based on deprivation of parental care or support due to absence of a parent from the home, the cabinet may:

1. Initiate a civil action or other legal proceedings to secure repayment of medical assistance expenditures for which the absent parent is liable; and
2. Provide for the payment of reasonable administrative costs incurred by such other state or county agency requested by the cabinet to assist in the enforcement of securing repayment from the absent parent. Enact. Acts 1980, ch. 252, § 4.

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I) The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data, of 1902(a)(25)(I) of the Social Security Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

Requirements for Third Party Liability -
Payment of Claims

1. For accident/trauma claims, the state has established a tI,o hundred and fifty dollar threshold amount in determining whether to seek reimbursement from liable third parties based on an accumulation of claims processed within a prior ninety day period, but with recoupment applied to all accumulated accident/trauma claims processed within a prior two year period.

2. The exception to the above policy is accident cases in litigation over $250 (two hundred and fifty dollars). These cases will be pursued from the date the accident occurred, regardless of the ninety day period and two—year time period.

3. Effective July 1, 1988, for claims that are not cost avoided pursuant to Kentucky's approved waiver, there is a $25 threshold with the $25 accumulated throughout each calendar quarter.

4. The provider's compliance with the billing requirement in situations involving medical support enforcement by the state Title IV-D agency is determined by having the liable third parties notify the state at the time of the state's quarterly billing if the provider has not complied with the billing requirement. Duplicate payments will be recouped.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

| Citation | Condition or Requirement |
|---|---|

1906 of the Act — State Method on Cost Effectiveness of Employer-Based Group Health Plans

A Cost Effectiveness

(1)Enrollment in a group health insurance plan shall be considered cost effective when the cost of paying the premiums, coinsurance, deductibles and other cost-sharing obligations, and additional administrative costs is estimated to be less than the amount paid for an equivalent set of Medicaid services.

(1) When determining cost effectiveness of a group health insurance plan, the department shall consider the following information:
   a. The cost of the insurance premium, coinsurance, and deductible;
   b. The scope of services covered under the insurance plan, including exclusions for pre-existing conditions, exclusions to enrollment, and lifetime maximum benefits imposed;
   c. The average anticipated Medicaid utilization:
      1. By age, sex, and coverage group for persons covered under the insurance plan; and
      2. Using a statewide average for the geographic component;
   d. The specific health-related circumstances of the persons covered under the insurance plan; and
   e. Annual administrative expenditures of an amount determined by the department per Medicaid participant covered under the group health insurance plan.

B. Cost Effectiveness Review.

(1) The department shall complete a cost effectiveness review:
   a. At least once every six (6) months for an employer-related group health insurance plan; or
   b. Annually for a non-employer-related group health insurance plan.

(2) The department shall perform a cost effectiveness re-determination if:
   a. A predetermined premium rate, deductible, or coinsurance increases;
   b. Any of the individuals covered under the group health plan lose full Medicaid eligibility; or

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

c. There is a:
1. Change in Medicaid eligibility;
2. Loss of employment when the insurance is through an employer; or
3. A decrease in the services covered under the policy.

(3) Changes in enrollment
a. A health insurance premium payment program participant, who is a Medicaid enrollee, or a person on that individual's behalf, shall report all changes concerning health insurance coverage to the participant's local Department for Community Based Services (DCBS), Division of Family Support within ten (10) days of the change.
b. Except as allowed in section (4) below, if a Medicaid enrollee who is a health insurance premium payment program participant fails to comply with paragraph (a) of this subsection, the department shall disenroll the HIPP program participating Medicaid enrollee, and any family member enrolled in the HIPP program directly through the individual if applicable, from the HIPP program.

(4) The department shall not disenroll an individual from HIPP program participation if the individual demonstrates to the department, within thirty (30) days of notice of HIPP program disenrollment, good cause for failing to comply with subsection (3) of this section.

(5) Good cause for failing to comply with subsection (3) of this section shall exist if:
a. There was a serious illness or death of the individual, parent, guardian, or caretaker or a member of the individual's, parent's guardian's, or caretaker's family;
b. There was a family emergency or household disaster – for example a fire, flood, tornado, or similar;
c. The individual, parent, guardian, or caretaker offers a good cause beyond the individual's, parent's, guardian's, or caretaker's control; or
d. There was a failure to receive the department's request for information or notification for a reason not attributable to the individual, parent, guardian, or caretaker or lack of a forwarding address shall be attributable to the individual, parent, guardian, or caretaker.

C Coverage of Non-Medicaid Family Members.

(1) If determined to be cost effective, the department shall enroll a family member who is not a Medicaid enrollee into the HIPP program if the family member has group health insurance plan coverage through which the department can obtain health insurance coverage for a Medicaid-enrollee in the family.

(2) The needs of a family member who is not a Medicaid enrollee shall not be taken into consideration when determining cost effectiveness of a group health insurance plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

(3) The department shall:

a. Pay a HIPP program premium on behalf of a HIPP program participating family member who is not a Medicaid enrollee; and
b. Not pay a deductible, coinsurance, or other cost-sharing obligation on behalf of a HIPP program-participating family member who is not a Medicaid enrollee.

State/Territory: _____Kentucky_____

| Citation | | Sanctions for Psychiatric Hospitals |
|---|---|---|
| 1902(y)(1), 1902(y)(2)(A) And Section 1902(y)(3) of the Act (P.L. 101-508, Section 4755(a)(2)) | (a) | The State assures that the requirements of section 1902(y)(l), section 1902(y)(2)(A), and section 19O2(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(A) of the Act | (b) | The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements f or a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients. |
| 1902(y)(1)(B) of the Act | (c) | When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:<br>1. terminate the hospital's participation under the State plan; or<br>2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or<br>3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding. |
| 1902(y)(2)(A) of the Act | (d) | When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period. |

State: _____Kentucky_____

| Citation | Sanctions for MCOs and PCCMs |
|---|---|
| 1932(e)<br>42 CFR 428.726 | (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:<br><br>(b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:<br><br>(c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by ('MS under 42 CFR 438.730(e).<br><br>☒ Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs. |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS
TO HOMELESS INDIVIDUALS

Medicaid cards are held in the local public assistance offices for pick-up by homeless individuals.

THE HEALTH CARE SURROGATE ACT OF KENTUCKY

Also enacted into law by the 1990 session o the Kentucky General Assembly and the Governor was Senate Bill No. 88, the Health Care Surrogate Act of Kentucky, which is codified at KRS 311.970-386 and allows an adult of sound mind to make a written declaration which would designate one or more adult persons who could consent or withdraw consent for any medical procedure or treatment relating to the grantor when the grantor no longer has the capacity to make such decisions. This law requires that the grantor, being the person making the designation, sign and date the designation of health care surrogate which, at his option, may be in the presence of two adult witnesses who also sign or he may acknowledge his designation before a notary public without witnesses. The health care surrogate cannot be an employee, owner, director or officer of a health care facility where the grantor is a resident or patient unless related to the grantor.

Except in limited situations, a health care facility would remain obligated to provide food and water, treatment for the relief of pain, and life sustaining treatment to pregnant women, notwithstanding the decision of the patient's health care surrogate.

DURABLE POWER OF ATTORNEY

A person may execute, pursuant to KRS 386.093, a document known as a durable power of attorney which would allow someone else to be designated to make decisions regarding health, personal, and financial affairs notwithstanding the later disability or incapacity o the person who executed the durable power of attorney.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

---

The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at S488.404(b)(l):

None

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

Termination of Provider Agreement: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy

(Will use the criteria and notice requirements specified in the regulation.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

Temporary Management: Describe the criteria (as required at S1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

☐ Specified Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

Denial of Payment for New Admissions: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER 1ITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

Civil Money Penalty: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

| | | | |
|---|---|---|---|
| ☒ | Specified Remedy<br><br>(Will use the criteria and notice requirements specified in the regulation.) | ☐ | Alternative Remedy<br><br>(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.) |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

State Monitoring: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

---

Enforcement of Compliance for Nursing Facilities

---

Transfer of residents: Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A))

☒ Specified Remedy
(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy
(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

---

Additional Remedies: Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

DEFINITION OF SPECIALIZED SERVICES

**Mental Illness;**

Specialized services (active treatment) is defined as the implementation of an individualized plan of care developed and supervised by a physician and provided by an interdisciplinary team of qualified mental health professionals, that prescribes specific therapies and activities for the treatment of persons who are experiencing an acute episode of serious mental illness, which necessitates continuous supervision by trained mental health personnel. Specialized services (active treatment) require the level of intensity provided in a psychiatric inpatient service.

**Mental Retardation**

Specialized services (active treatment) is defined as the continuous aggressive and consistent implementation of a program of specialized and generic training, treatment, health and related services, which are comparable to services an individual would receive in an Intermediate Care Facility for the Mentally Retarded (ICF/MR), and in the Alternative Intermediate Services for Mental Retardation (AIS/MR) Waiver Program where 24-hour supervision is available that is directed toward: (1) the acquisition of the skills necessary for the person to function with as much self - determination and independence as possible; and (2) the prevention or deceleration of regression or loss of current optimal functional status. {NOTE: Continuous is defined as the interaction, at all times and in all settings, between staff and individuals served, in the implementation of specific Individual Program Plan (IPP) objectives.}

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

CATEGORICAL DETERMINATIONS

**Advance Group Determination for Nursing Facility Level of Care**
**(Provisional Admission for up to 14 Days)**

An advance group determination, or provisional admission, is one in which the Level I reviewer, after nursing facility certification, takes into account certain diagnoses or the need for a particular service which clearly indicates that admission into or residence in a nursing facility is normally needed. Persons who enter the nursing facility under the provisional admissions category do not require an individualized evaluation to determine that specialized services are needed prior to admission. However, a request for a Level II PASARR should be made within nine (9) days of admission with each provisional admission if they are not going to be discharged within the fourteen (14) days. This allows the PASARR evaluator five (5) days to provide a verbal determination.

Provisional Admissions
(Nursing Facility Placement up to 14 Days)

1) A diagnosis of delirium as defined in the OSMITIR, allows for a fourteen (14) day admission pending further assessment, when an accurate diagnosis cannot be made until the delirium clears.
2) Respite is allowed to in-home care givers to whom the person with mental illness or mental retardation is expected to return following a fourteen (14) day or less stay.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUTREMENTS

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Survey and Certification Education Program

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The State has in effect the following survey and certification periodic educational program for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies.

State staff participate in regular and periodic provider training events. This participation includes serving as presenters and panel members as well as conducting sessions on regulations changes and implementation. Provider representatives include both administration and direct case staff. State staff also participate in resident council meetings and will be providing other training for facility residents and/or responsible parties as time and staff permit.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for the Investigation of Allegations of Resident Neglect
and Abuse and Misappropriation of Resident Property

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The State has in effect the following process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a resident in a nursing facility or by another individual used by the facility in providing services to such a resident.

All allegations of abuse, neglect and misappropriation of resident property are immediately investigated by Division of Licensing and Regulation and Department for Social Services in a joint effort. During this investigation the accused individual is advised of the alleged incident. Prior to a final determination of substantiation the accused individual is afforded the opportunity to appeal. All substantiated investigations are subject to the appropriate appeal process. Substantiated cases of Nurse Aide abuse, neglect and/or misappropriation are entered on a centralized registry maintained by the State Survey Agency. The accused individual and all appropriate authorities are notified of the final determination and action taken.

STATE PLAN UNDER TITLE: XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONSAND REQUIREMENTS

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Procedures for Scheduling and Conduct of Standard Surveys

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The State has in effect the following procedures for the scheduling and conduct of standard surveys to assure that it has taken all reasonable steps to avoid giving notice.

In addition to federal procedures, the Division of Licensing and Regulation is prohibited by state law from giving any advance notice of long-term care facility surveys. Surveys to be conducted in a given month are sent to our regional offices. Schedulers in regional offices do not release schedules to staff until approximately one week prior to survey. Master schedules in regional offices are closely guarded.

Kentucky uses a flexible survey schedule where some facilities are surveyed in ranges of 9 to 15 months. Survey schedules are also based on performance in previous surveys and the number of complaints made against a facility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Programs to Measure and Reduce Inconsistency

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The State has in effect the following procedures to measure and reduce inconsistency in the application of survey results among surveyors.

Annual training sponsored by Licensing and Regulation plus quarterly in-service training in Regional Offices on specific problem areas that need addressing for statewide consistency in the application of the survey process. Basic training and other specialized courses are provided by HCFA. Also, all survey packets received in Central Office are reviewed by compliance analysts.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____Kentucky_____

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Process for Investigations of Complaints and Monitoring

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The State has in effect the following process for investigating complaints of violations of requirements by nursing facilities and monitors onsite on a regular, as needed basis, a nursing facility's compliance with the requirements of subsection (b), (c), and (d) for the following reasons:

(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

(ii) the facility was previously found not to be in compliance with such requirements and has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

(iii) the State has reason to question the compliance of the facility with such requirements.

Refer to Attachment 4.40-C

All allegations of facility violations are investigated by the Division of Licensing and Regulation. All deficiencies resulting in Level A noncompliance are followed up for correction.

**Method for establishing Employee Education**
**Of False Claim Policies and Procedures**

1. The Department will query the Decision Support System (DSS) for FFY 2006 Fee-for-Service and Encounter Data as of January 1, 2007 to identify entities for the purposes of section 6032 of the Deficit Reduction Act of 2005 with distinct Federal Employer Identification Number (FEIN) receiving over $5,000,000.

2. Each entity from the query in step 1, will be sent a provider letter reminding them that their provider agreement requires them to comply with all applicable State and Federal laws and advising them that the Deficit Reduction Act of 2005 section 6032 contains a new requirement that must be met. Any entity paid through the Medicaid FMAP signs the aforementioned provider agreements in order to receive a provider number and the ability to bill. This includes Passport, Transportation Brokers, and other state agencies. The letter will include a form that must be signed and returned certifying that they meet the following requirements from section 1902(a)(68) of the Social Security Act:

   A. Establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

   B. include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

   C. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

3. The entities will attach relevant documents in meeting the requirements from 1902(a)(68) of the Social Security Act. Relevant documents include but are not limited to policy memos, employee handbook, and any document that demonstrates how the entity satisfies the requirements. Responses will be due to the Department by September 1, 2007.

4. The Department will evaluate the entities responses, and certify the response as valid or state the reasons the conditions were not met in a response back to the entity by December 31, 2007.

5. For future years beginning with FFY 2009, a reassessment will occur at least every three years to ensure compliance with 1902(a)(68) of the Social Security Act. The following deadlines will apply in the given year:

   A. Un-duplicated providers from the previous FFY's DSS query meeting the same criteria in step 1 as of January 1 following the end of the respective FFY will be sent the entity letters from step 2 by March 31 of the respective year;

   B. Entity response to the letter will be due by June 30 of the respective year; and

   C. The Department will send the response to the entity by September 30 of the respective year. The Department letter will validate the entities response' or state the reasons the conditions were not met.

MEDICAL ASSISTANCE PROCRAM

STATE OF _____KENTUCKY_____

KENTUCKY CITATION LISTING

1. Kentucky revised statutes, Chapter 18, on State Personnel, as amended through February 22, 1972, including the understanding contained in the March 16, 1972, letter from Carl V. Beeler, then Chief, Division of Inter-governmental Personnel Programs, USCSC, to Miss Cattle Lou Miller, Kentucky Commissioner of Personnel, that in the Grant-Aided Agencies the Federal standards must determine which assistant or deputy may be exempted from coverage. Also included is the understanding contained En paragraph 3 of the March 16, 1972, letter that the only effect of Section 3 (1) and Section 4 (1) and (2), of House Bill Number 120, is to remove the Commissioner of Personnel class from Merit System coverage and to revise the method of appointment to authorize direct appointment by the Governor.

2. Personnel rules of the Kentucky Department of Personnel, as amended through March 9, 1973, including the understanding contained in the October 31, 196I, letter from the Kentucky Commissioner of Personnel to the Regional Merit System Representative that provisional appointments will not be made or continued if there are as many as three (3) available eligibles for a position.

3. Policy memoranda in effect through November 25, 1970, which were issued by the Commissioner of Personnel to all Department and Agency Heads.

MED1CAL ASSISTANCE PROGRAM

STATE OF _____Kentucky_____

METHODS OF ADMINISTRATION - CIVIL RIGHTS

The state agency's implementing methods of administration of the medical assistance program to ensure non-discrimination have been submitted and are on file.

I. Assignment of Responsibility

Responsibility for ensuring that Title VT compliance is maintained rests with the Coordinator, Civil Rights, Department for Human Resources. In accordance with administrative structure of the Department for Human Resources, Title VI reviews of hospitals, nursing homes and intermediate care facilities are conducted by the Division for Licensing and Regulation, Bureau for Administration and Operations, in conjunction with the Division's on-site validation surveys.

II. Dissemination of Information

A check insert was sent to all recipients of assistance in 1965 to advise that the adult and children's programs and medical assistance would be administered in accordance with the Civil Rights Act of 19614. The insert specified that no discrimination would be made due to race, color, or national origin, and that applicant or recipient who felt he was discriminated against for these reasons had the right to appeal. A pamphlet titled "Kentucky Public Assistance and Civil Rights" was prepared to explain the Civil Rights Act and was mailed to recipients of assistance payments to further advise them of the provisions of the Act. A copy of the pamphlet is given to each new applicant. Any applicant or recipient who appears not to understand his civil rights is given a complete verbal explanation to supplement the written material, and it is agency practice that in any initial interview with an applicant for assistance the worker summarizes the Title VI provisions and provides answers to any questions.

The Civil Rights pamphlet specifies the agency's compliance with Title VI, explains that applicants and recipients of federally aided programs will not be discriminated against by the agency or vendors of services, and that the applicant or recipient who feels he has been discriminated against may request a hearing with the agency or make the allegation of discrimination to the Kentucky Commission on Human Rights, Frankfort, Kentucky, or the Secretary of Health, Education, and Welfare, in Washington, DC.

MEDICAL ASSISTANCE PROGRAM

STATE OF: _____Kentucky_____

METHODS OF ADMINISTRATION - CIVIL RIGHTS

The Manual of Operation of the Bureau for Social Insurance specifies that the Federal Government has been assured that public assistance programs will be administered in such a manner that no person is to be excluded from any benefits under the program or otherwise subjected to any discrimination on the grounds of race, color or national origin. Pamphlets, check inserts and similar civil rights material made available to applicants/recipients are also made available to staff, and circulars, memoranda, and similar communicative devices are used to further advise staff of actions required for compliance with the Civil Rights Act. Agency training and orientation for new workers provide explanation of Title VI of the Civil Rights Act and instructs workers in techniques of non-discrimination. Supervisory personnel are also1 from time to time, used to re-emphasize to agency workers the importance of non-discrimination and to correct any local practices which may be interpreted as discriminatory, whether real or potential.

Vendors are provided with Civil Rights information by pamphlets, Circulars or other appropriate means, and where required by Federal regulation their agreement to participate includes their agreement not to discriminate due to race, color or national origin. The billing system is designed so as to contain a statement to the effect that services provided under the Medical Assistance Program are provided without discrimination due to race, color or national origin.

The General Public is made aware of the agency's continuing compliance with Title VI by the use of public information releases to newspapers or other-news outlets at intervals as necessary.

III Maintaining and Assuring Compliance

Pursuant to federal regulations and utilizing federal guidelines on-site reviews are conducted at least annually of all participating hospitals, skilled nursing facilities and intermediate care facilities, unless a satisfactory and similar review for Title XVIII purposes has been accomplished for that period of time. The on-site review is conducted by trained personnel of the Division for Licensing and Regulation, Bureau for Administration and Operation, as an integral part of their annual on-site validation survey of these facilities, and includes a- survey of the physical facility, interviews with appropriate facility employees and patients, and an evaluation as to any actual or potential areas of discrimination.

MEDICAL ASSISTANCE PROGRAM

STATE OF _____Kentucky_____

METHODS OF ADMINISTRATION CIVIL RIGHTS

The Bureau does not conduct regular on-site reviews for Civil Rights compliance monitoring of physicians, dentists, etc. However, the Bureau for Social Insurance has personnel assigned to specific area development districts who have as one of their functions vendor liaison to assist vendors in overcoming problems related to client identification, billing, program changes, etc. These liaison personnel do as a part of their assigned responsibility visit the offices, clinics and other facilities of individual vendors and would observe any overt or manifest indications of discriminatory practice or treatment. Whether discovered through the Title VI on-site review or other contact, any suspected discriminatory practice is investigated to determine the facts of the situation, and an evaluation as to actual or potential discrimination is made.

Should a discriminatory practice be found, the Bureau takes immediate action to secure compliance. In accordance with federal directives the individual, organization, or agency found to be in actual or potential non-compliance with the Civil Rights Act and agency practice in the provision of medical and related services is afforded the opportunity to voluntarily comply with the requirements. In the event efforts to solicit voluntary compliance fail, all available sanctions provided for in the law and regulations are invoked, including removal of a vendor from participatory status in all appropriate instances.

IV. Handling Complaints

At the time the client alleges discriminatory treatment, the local worker explores the situation and attempts to resolve it to the satisfaction of the client on an informal basis. If such resolution is not possible, the client may appeal through the usual hearing process, or file a complaint of discrimination based on race, color, or national origin.

When the client alleges that he is being denied eligibility for a money payment or medical assistance through discriminatory agency policy, or discriminatory application of agency policy, he would ordinarily use the hearing process which provides for determinations as to eligibility for benefits. The process includes a hearing before a Hearing Officer of the Bureau, recourse to the Appeal Board for a review of the Hearing Officer's decision, and final recourse to the judicial system. The complainant is afforded the right to counsel, or other representation of his choice, throughout the process. He may submit written or oral statements or other material to substantiate his allegation, and may appear personally to present evidence or have the case Judged on the merits of the evidence previously introduced, during the review by the Appeal Board.

A finding of discrimination established through the hearing process i considered binding on the agency, and decisions made to alleviate current discrimination or prevent future occurrences of a similar nature are implemented to the fullest possible extent by the agency.

When the client reports discrimination in the manner of provision of services, or refusal of access to medical benefits to which he is entitled, due to rice, color or national origin, he would ordinarily use the complaint of discrimination process, which provides for correction of the situation through removal of a vendor in non-compliance status from participating status with the program. The complaint of discrimination is formally filed through completion of the Complaint of Discrimination form, which is immediately forwarded to the Area Manager for action.

Following action by the Area Manager, the client has further recourse to the Coordinator, Civil Rights, Department for Human Resources and to be Kentucky Commission on Human Rights. The client is afforded opportunity to substantiate his complaint of discrimination, and appropriate investigation is made at each responsible level. The Coordinator, Civil Rights, will maintain a file of all complaints made on the basis of discrimination, and the resolution of such complaints. (See attached Flow Chart, Attachment 7.2-A.l.)

The Ombudsman, Department for Human Resources, will receive complaints on discrimination that are addressed to that office by the client, and will forward such claims to the Coordinator, Civil Rights, for resolution.

The Director of the Division for Medical Assistance will remove from participatory status any vendor practicing discrimination if voluntary compliance cannot be secured, based on a finding of the Coordinator, Civil Rights, Department for Human Resources, or the Kentucky Human Rights Commission.

Recruitment and Training Programs

Agency recruitment is in accordance with Title VI of the Civil Rights Act, Chapter 18 of the Kentucky Revised Statutes, State Personnel Rules, and Public Assistance Regulation Number 14. Race, color, or national origin are not factors in recruiting, hiring, upgrading, conditions of employment, dismissals, referrals and training programs. In-service training is provided on a uniform basis to all employees, and training staff of the agency is the basis of merit, and minority group employees are made aware of such training programs and given the opportunity to participate.

MEDICAL ASSISTANC PROGRAM

STATE OF _____Kentucky_____

FLOW CHART - HANDLING CIVIL RIGHTS COMPLAINTS

Description and analysis, Flow Chart: Methods of Handling Complaints of Discrimination due to Race, Color, or National Origin.

1. The Bureau for Social Insurance worker receives the complaint and resolves it informally if possible. Based on a preliminary determination of facts, the client is advised as to the most appropriate appeal procedure. The Complaint Form, PA-664, is completed in all appropriate instances by the client (with the assistance of the worker) and is forwarded to the BSI Area Manager for corrective action.

2. The Area Manager conducts a preliminary or limited investigation to establish the basic facts of the situation. If discrimination is established, the Area Manager win attempt to informally persuade the person or facility practicing discrimination to amend the practice in question. The client will be notified of the disposition of the complaint, and the complaint and a copy of the resolution statement to the client will then be forwarded to the Coordinator, Civil Rights, Department for Human Resources. When the Area Manager is unable to resolve the complaint, the evidentiary data secured will be forwarded to the Coordinator for his further use. The Area Manager will maintain a Civil Rights Complaint File. The client may request further action by the Coordinator, Civil Rights, if not satisfied with the Area Manager's complaint resolution.

3. The Coordinator, Civil Rights, Department for Human Resources, will acknowledge receipt of any unresolved complaint and conduct/direct an immediate investigation to fully establish the facts and circumstances alleged in the complaint. If discriminatory practices are found, the Coordinator will seek to secure voluntary compliance through informal persuasion, and will notify the client of the resolution. Should a discriminatory practice not be voluntarily ended, a statement of findings would be forwarded to the Director, Division for Medical Assistance, for corrective action. A resolution by the Coordinator not satisfactory to the client would result in the complaint being forwarded to the Kentucky Commission on Human Rights for further action.

4. When a statement of findings is forwarded to the Director, Division for Medical Assistance, for corrective action the Director will afford the vendor the opportunity to voluntarily comply, prior to removal of the vendor from participatory status. When. the complaint is referred to the Commission on Human Rights (HRC) for resolution, the HRS establishes legitimacy and validity of the complaint, conducts any necessary investigations and holds a hearing as appropriate, and attempts informal persuasion to secure voluntary compliance. A report of compliance or hearing report is issued.

5. When the report of HRC is reviewed by the Director, Division for Medical Assistance, the Director ensures that required corrective action is taken. When voluntary compliance by a vendor cannot be secured, removal of the vendor from participatory status will be accomplished.

Department for Human Resources, Bureau for Social Insurance Flow Chart depicting the handling of complaints of discrimination due to race, color or country of national origin.